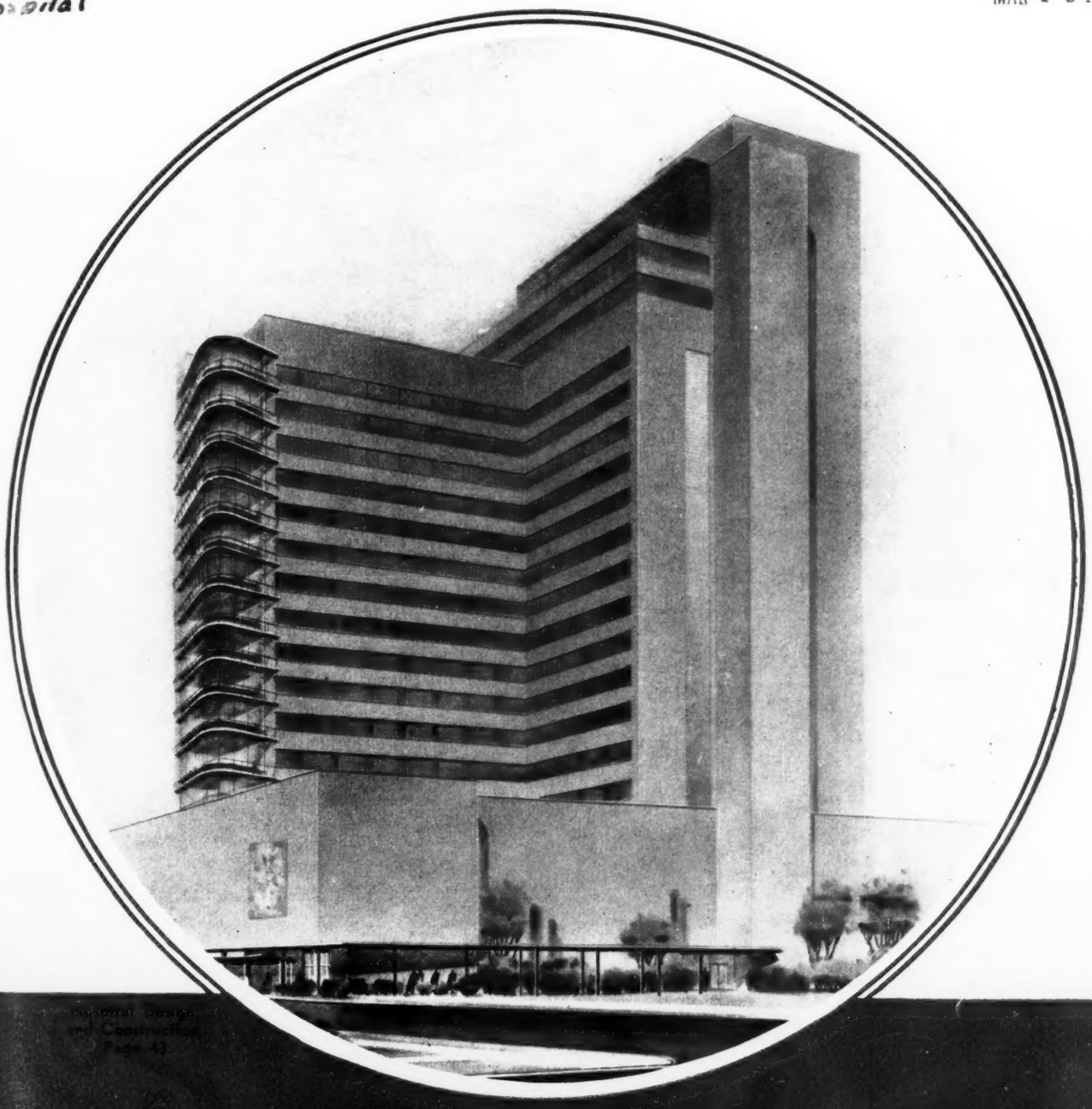

and Construction
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# the MODERN HOSPITAL

VOLUME 66 MARCH 1946 NUMBER 3

# SMALL HOSPITAL QUESTIONS

**Conducted by Gladys Brandt, R.N., Detroit Medical Hospital, Detroit, Michigan: Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.**

## High Labor Turnover

**Question: What is the effect upon hospital public relations of an excessively high rate of labor turnover?—R.C., Pa.**

ANSWER: High labor turnover makes it difficult to maintain high quality service. New employes are not so familiar with hospital routines and traditions of service. They are least adept in their duties. They may give wrong information or wrong impressions about the hospital.

A more important aspect is what to do about it. Now that Peace is here and millions of workers have lost war jobs, it should again be possible for hospitals to find some competent and stable workers. Undoubtedly, wages in hospital employment will stay at or near their present levels. Many hospital administrators welcomed the opportunity provided by the war to raise the level of wages. Furthermore, hospitals are thinking favorably about pension plans, social security protection, adequate vacations, sick leave and other personnel policies.

As we provide good positions, so we should expect good standards of work from our employes. It is an economy to employ a competent person at a good salary rather than two incompetent persons at half the salary.

Special efforts should be made to train all employes — those newly employed, those employed during the war and the old faithfuls that stayed with us from prewar days—in the technics of good public contacts. In this connection, read again the article by Milo Anderson in the September issue of The MODERN HOSPITAL on the training used at the University of Chicago. A small hospital can do the same. Also, it would be well to distribute to all employes and volunteers copies of the booklet entitled "When We Enter the Sickroom." This originally appeared in this magazine in January 1944. Sets of pages are still available for those who wish to have them planographed.—A. B. M.

## When Is the Nurse Liable?

**Question: Who determines the duties of a general duty nurse? Winding up a patient's bed might be judged by the court as the duty of a porter, should something happen to the patient (in Canada).—A.B., Ohio.**

ANSWER: The usual professional duties of a nurse deal with the medical care of the patient under the specific or general instructions of the attending physician. In addition, the hospital may assign to her such nonprofessional work as may be customary or necessary. When a patient is injured by reason of the nurse's negligence in the performance of her professional skill, there is no liability on the part of the hospital, for she is deemed to be acting as the servant of the attending doctor. However, for her carelessness in purely ministerial or administrative duties, such as winding up the bed of a patient or changing bed sheets, in which she serves as a mere employe of the hospital, acting under the instructions of the administration, the hospital would be responsible if the patient is injured. (Reference: "Rule of Immunity for Hospitals Is Narrowed by Recent Court Decisions," Emanuel Hayt, *Hospitals,* September 1944.)—EMANUEL HAYT.

## Isolation in a General Hospital

**Question: Can a general hospital operate a communicable disease unit in close connection with the hospital or should it be located at a distance?—J.D., Mich.**

ANSWER: Yes, all health authorities now agree that with personnel that is properly trained in the technic of caring for communicable diseases it is entirely safe to operate such a unit as a section of a general hospital. The incidence of communicable diseases fluctuates so violently that it would be well to arrange the unit so that the various rooms can be used for other types of patients about 80 per cent of the time.

Many nonquarantinable diseases like gas gangrene require the use of proper isolation technic and are usually cared for in a general hospital. If the general hospital has an isolation unit it is helpful to put such cases in that unit, thus helping to keep up the average occupancy in the unit and relieving the load on the rest of the hospital. The total occupancy in the hospital is thus increased, the cost per day in the isolation unit is decreased and the nursing staff keeps busy and keeps in practice.

Much time can be saved by the doctors if a hospital provides an isolation department, since it is much easier for them to see their patients with communicable diseases in the hospital than it is in the home.

The number of beds that would seem to be required for a population of 20,000, according to the figures recently compiled by the Pennsylvania Hospital Association, is from four to six.—E. W. JONES.

## For Better Staff Meetings

**Question: What can a staff nurse do to assist in building up an interesting staff conference and meeting in a small hospital?—E.M., Ill.**

ANSWER: A staff nurse in a small hospital can participate in a staff conference only if she is appointed by members of the staff to aid in the preparation of the program for the conference, or if appointed as the nurse to attend patients brought to the conference.

The nurse in a small hospital can help to prepare these programs but she should not take part in the presentation of a clinical or pathological conference subject. Certainly, the genuine interest of a staff nurse towards helping in a small hospital's teaching program can be fostered in cooperation with the chairman of the medical staff and the superintendent of the hospital.—ROBERT F. BROWN, M.D.

## How Wide Is a Door?

**Question: What are the standard widths for (1) corridor doors to nursing units, (2) nursing unit corridors, (3) ward doors?—J.P., Tex.**

ANSWER: (1) Corridor doors to nursing units should be not less than a single door 4 feet wide. Some prefer a pair of doors, but it has been our observation that when a pair of doors, say 5 feet wide, is used, the tendency is to try to get rolled equipment through a single leaf of such a door. (2) Nursing unit corridor doors (if there are any, and I don't know why there should be any within the nursing unit itself) should also be 4 feet wide. (3) Ward doors, again, should be 4 feet wide, although sometimes they may be as narrow as 3 feet 8 inches.—CARL A. ERIKSON.

## Can They Be Trusted?

**Question: Should student nurses be entrusted with the care of premature infants?—O.G., Nev.**

ANSWERS Yes, student nurses should be entrusted with the care of premature infants but under direct supervision of a graduate nurse with training in obstetrics, with emphasis on premature care beyond that which received in the usual three year course of study.—MARY A. MITCHELL.


# *Check the* B.M.R.

The basal metabolic rate is still the most significant criterion in diagnosing hypothyroidism. And the goal of therapy in hypothyroidism is the restoration and maintenance of a normal B. M. R. To attain this goal a thyroid preparation of dependable, unvarying potency and accurate standardization is essential. To this end, THE ARMOUR LABORATORIES, pioneers in this field, has long led the way in developing new and better methods of preparing medicinal thyroid from the world's largest supply of fresh animal material.

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# LOOKING FORWARD

## Shame!

HERE and there, evidence is appearing that we did not mean what we said to the doctors and hospital administrators who went away to war. We did not mean what we said when they left, it now develops, and we did not all mean it when we said we were glad to have them back.

For example, returning doctors are having a hard time finding office space; individual suites are not to be had in most communities, and groups of doctors sharing the same offices are often reluctant to make room for a returning colleague at the cost of any inconvenience to themselves. Too, there are stories indicating that occasionally the doctor who comes back and reopens his office is made to feel more like an interloper than a comrade.

Patients' histories come slowly from the offices of the doctors who have cared for them during the war years. Hard to get under the best of circumstances today, hospital accommodations are sometimes virtually inaccessible for the patients of newly returned veteran physicians; one hospital staff reportedly invoked its two year residence law to deny privileges to a doctor who had been in good standing when he left to enter the service.

Worst of all, perhaps, is the case of the hospital administrator who came back recently and found the board of trustees of his hospital unwilling to make any move toward giving him back his old job. The trustees were satisfied with the person who had replaced him and they suggested that he make other arrangements. To a man who had performed creditably on the job for a number of years before he went out to build and operate hospitals under enemy gunfire thousands of miles from home, this kind of treatment was a shocking demonstration that the "undying gratitude" described by the ads and the orators was so much hogwash.

Of course, every man in uniform was not a hero. Some of them had a much softer time of it than those who stayed behind. But the overwhelming majority of the professional men and women who went away did so at considerable sacrifice; what they did in the war depended for the most part on circumstance rather than on choice or ability and should have no great bearing on the reception they are entitled to now. Moreover, absence from home and boredom are listed among the severe hardships of war even by front-line soldiers, and everybody in uniform did suffer these.

Generally speaking, business and industry have made good on their promises to people who went to war. Most of them have their old jobs back, or they have better jobs. Others are getting a helping hand in looking for a place or starting a business. It is unthinkable that the hospital and medical professions, with their high humanitarian purposes, should take a selfish attitude where industry takes a generous one. Meanness is bad enough anywhere, but it is particularly shameful in those who profess lofty professional ideals.

## One Purse

THE amounts of money that are raised every year by voluntary subscriptions to help combat tuberculosis, infantile paralysis, cancer and heart disease have little or nothing to do with the comparative importance of these diseases as enemies of the public health. The public pocketbook is tapped, separately and successively, by various agencies in these and other health fields, with results that depend not especially on merit or need but chiefly on the organization and publicity skills which are brought to bear on the several problems.

Recently, for example, a high-powered national campaign thumped the tub for the Sister Kenny Institute in Minneapolis. Scarcely had Bing Crosby, Sister Kenny's quarterback, retired from the field, when the National Foundation for Infantile Paralysis, using a new line-up of Hollywood personalities, took over. Certainly these are worthy causes—that point need not be disputed. But it cannot be denied that the amount of money raised in these two campaigns gives infantile paralysis a grossly disproportionate share of the whole health purse.

Cancer and heart disease, which do not lend themselves as readily, perhaps, to the movie star technic, or whose publicity agents have different skills, or different tastes, are vastly more important as public health problems. Other diseases, such as diabetes, arthritis, ne-

phritis, influenza and penumonia, should be entitled to a generous share of the voluntary contributions for health but suffer now for lack of organization and fund-raising *schmalz*. Under today's conditions, a president of the United States with chickenpox or Asiatic cholera might quickly bring his ailment to the head of the list from the standpoint of public support.

Obviously, a national planning and coordinating agency of some kind is badly needed to avoid the duplications and inequities which are inevitable at present. Certainly, the public would respond generously and enthusiastically to a single appeal for funds each year to stimulate medical research and aid the victims of all the ills from which we suffer. Such funds would then be allocated to various projects on the basis of actual needs as assessed systematically by the interested and informed groups.

It is plain that many economies in effort and expense could be effected through such a national planning agency. Besides, it would cut down the wear and tear on movie stars.

## Required Reading

BOOK 3 of the "1945 Hospital Review," just published by the American Hospital Association, includes full accounts of actual House of Delegates' discussions of such problems as pensions for hospital employes, veterans' care, legislation affecting hospitals, Blue Cross and all the other major problems hospitals are facing today. Books 1 and 2 of this series, published earlier, included reports and special studies made by association officers, committees and councils. The entire series is required reading. For reference, for guidance and for inspiration, these books should be in every administrator's office, and the first two books, especially, should go to hospital trustees as well.

## Get Out of the Manger!

AT TODAY'S fast pace of national developments, the hospital that is out of step slows up the whole parade. As the work of the state survey groups is accelerated all over the country, occasional reports from field workers indicate that some institutions are still looking backward instead of forward. A few are refusing to complete the schedules of information requested in connection with the surveys; others avoid downright refusal but are half-hearted in their cooperation, delaying unreasonably or submitting manifestly incomplete or inaccurate schedules.

Everybody recognizes the difficulties encountered in completing these monumental questionnaires. The schedules are intricate and detailed—and they do go on and on and on! That many hospitals are hard put to it to find the time and personnel to finish them is certainly understandable. But it is also a fact that those who believe thoroughly in the necessity of this project are getting it done, no matter what the cost in perspiration and nerves, and it is just as hard for them as it is for the others.

With the federal hospital survey and construction bill well on the way to enactment, no one can dispute the importance of full, precise data on existing facilities as the essential foundation on which to build plans for the future of hospitals in America. Even those who do not believe in the bill, and there are few of these, must see that confusion and waste can be the only possible outcome of plans based on inaccurate estimates of the need, and that inaccurate estimates are inevitable unless every line of every page of every schedule is done promptly and done right.

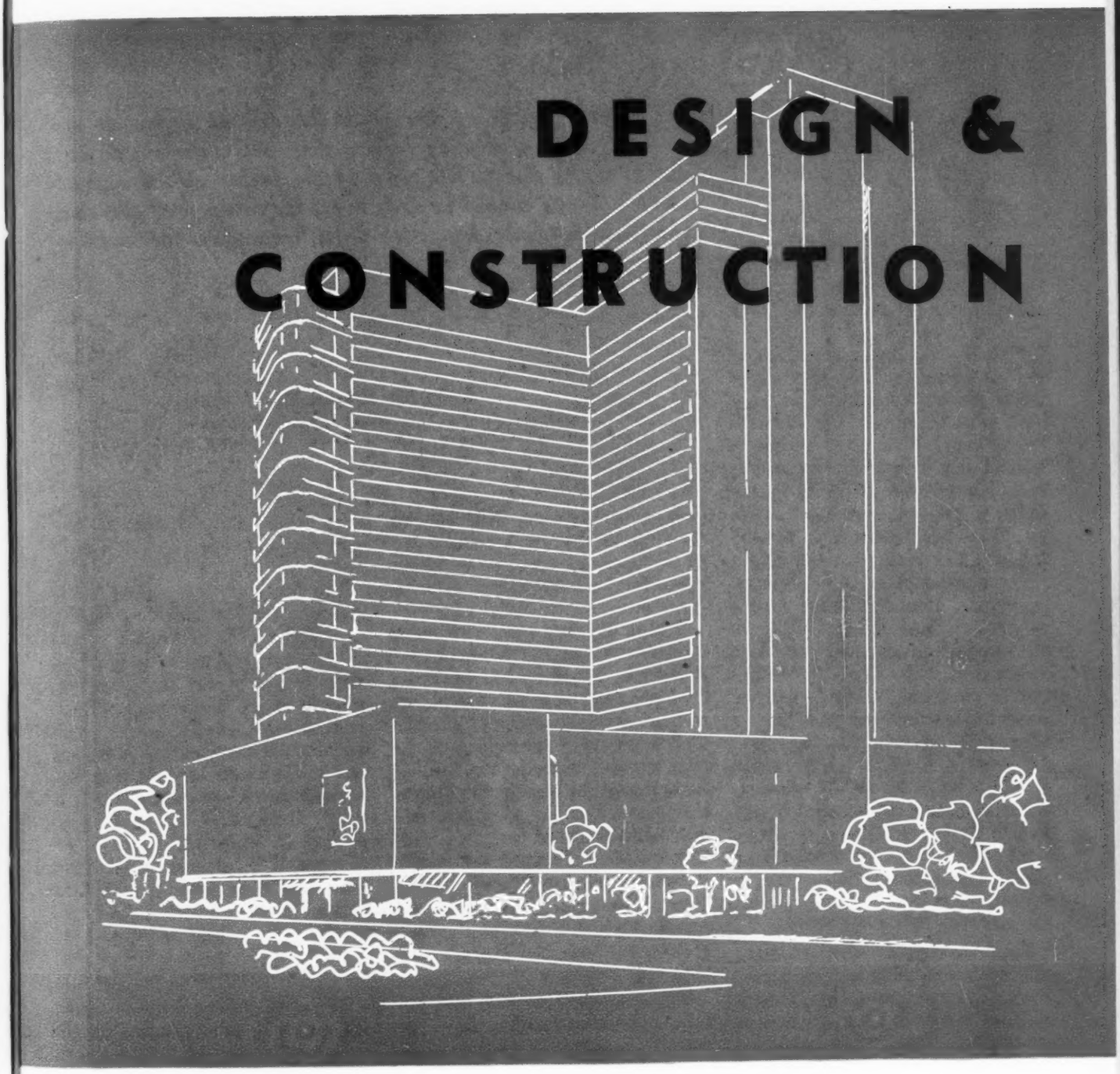
Nobody will criticize hospitals that are doing everything possible to get the job accomplished. But those that are holding back on their part in the surveys are playing dog-in-the-manger, an inappropriate rôle for institutions supposedly devoted to the public welfare.

## Two Kinds of Nurses?

IN THE opinion of many qualified observers, development of the scientific and professional aspects of nursing education in recent years has had the one unfortunate result of educating the nurse away from her patients. It is hard to say how this has happened; certainly, the practical nursing arts have not been neglected in our schools. Nevertheless, the increasing tendency of nurses to look upon the patient as a receptacle for certain symptoms calling for certain professional procedures, instead of as a human being who is suffering and whose most important need is for human sympathy and understanding, has been widely remarked.

Still more recently, the effectiveness of the various nurse's aide programs that have been developed during the war years has demonstrated the over-all economy of having the nonprofessional elements of bedside care handled by nonprofessional personnel. To many people this is proof that in future we must have two levels of nursing, professional and practical. Possibly this is the right solution, but there is danger that by introducing a nurse at another level we are simply interposing another buffer between the patient and the ultimate manager of his illness, the physician, who is already much farther removed from intimate, day-to-day contact with the patient than he should be. The complexities of modern scientific medical care, especially in hospitals, may make this removal inevitable. Perhaps there is no other answer. It is true that the addition of a practical nurse would give the patient more of the close personal attention to his human needs that is so desirable. But it is also true that the patient would lose something, too, by being made to feel that his care had been relegated to a comparatively unimportant and unknowledgeable person.

Many hospital patients complain today that they rarely see the doctor and he is too busy to talk to them when they do. Are they going to be saying the same thing about nurses?


DESIGN &
CONSTRUCTION

# BROADER SERVICE
## —*Greater Centralization*

***This review points up the great benefits to architects and administrators in sharing information and experience. In a field in which the public weal is the prime objective, much more could and should be done to get the findings of operating experience into the hands of those who plan the building***

**E. TODD WHEELER**
Architect, University of Illinois, Chicago Colleges
and Director of Planning, Medical Center Commission, Chicago

YOU, a hospital administrator, are going to expand your plant. It is your responsibility to submit a program to your trustees, your staff, your hospital consultant and your architect for study.

Probably the basic questions of size and location have been determined for you, but many other questions arise when you ask yourself: "How can I be sure of getting a hospital that is up to date when it is built but will be adaptable during its life to progressive change? What are the trends I must look for and follow? For example, what is the proper number of beds for each nursing station, 15 or 50? What are the special requirements for teaching in the hospital? How much can I centralize services for economy without loss in treatment, teaching and research? How will my building be affected by growing use of plans for hospital care? What provision should I make for public relations, home extension, social service, outpatient service, public health education? How much air conditioning should I plan for?"

### Long, Hard Job Ahead

Final answers to your questions will come only after long and hard work by you and all the professional planners concerned, but a glance at current trends may help in writing your program.

It is anyone's guess as to what constitutes a trend. Hindsight usually enables us to recognize postmortem the start of a movement, but at any given moment it is difficult to predict which of the many things being done are the beginnings of significant developments and which are superficial experiments soon to be forgotten. The best we can do is to appraise each idea and try to judge for ourselves its lasting merit, for the final test remains with experience.

Within the last year, visits to a number of teaching hospitals and discussions with their administrators have produced material from which certain conclusions seem possible. The number of interviews is far from comprehensive but the findings do represent the current thinking of a representative group of informed and active hospital administrators. The questions discussed are specific and controversial and those on which there is general agreement were not raised. They fall into two general groups: (1) basic facilities; (2) planning relationships.

The accompanying table summarizes the questions and findings. Answers indicate either what exists or what is being planned if that is different from the existing situation.

Two general conclusions seem justified from the information and opinions collected. The first is that planning is being directed toward a broader and more nearly complete service to patients and away from separate and special treatment. The second is that adjunct services are being centralized for economy and efficiency as far as possible without loss of quality.

The first trend seems to be in line with the current idea that medical service should be preventive as well as curative and that mental and social factors, as well as the physical, must be taken into account. It suggests that the hospital of the future will include out-patients, in-patients and public health services, with presumably fewer acute cases. Study of basic relationships in these three services is important if plans are to meet new requirements. More education of patients is a definite part of this trend and suggests the greater use of visual material.

### Adjunct Services Centralized

The second trend is toward more open nursing units grouped around more highly centralized adjunct services. The detailed comments that follow indicate that centralization can be carried only as far as quality will permit. It is found, for example, that teaching and research requirements for laboratories adjoining the hospital wards limit laboratory concentration, but there is no reason why good planning cannot reach a balance between efficiencies

## TABULATIONS OF QUESTIONS AND ANSWERS

| QUESTIONS | Hospitals | A | B | C | D | E | F | G | H | Conclusion |
|---|---|---|---|---|---|---|---|---|---|---|
| **BASIC FACILITIES** | | | | | | | | | | |
| 1 | Teaching in hospital | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | These are teaching hospitals |
| 2 | Number of adult beds | 470 | 850 | 520 | 980 | 1000 | 850 | 280 | 300 | And also large hospitals |
| 3 | Obstetrics included | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | They have the four major services |
| 4 | Emergency surgery service | Yes | No | No | Yes | Yes | Yes | Yes | Yes | Emergency surgery desirable for teaching |
| 5 | Isolation delivery unit | Yes | Yes | — | Yes | Yes | No | Yes | Yes | Isolation delivery unit desirable |
| 6 | Premature station | — | Yes | — | Yes | Yes | — | Yes | — | Premature station desirable |
| 7 | Home extension services | No | No | No | No | No | OB | No | No | There should be more |
| 8 | Special public relations effort | No | No | No | Yes | No | Yes | No | No | There should be more |
| **PLANNING RELATIONSHIPS** | | | | | | | | | | |
| 1 | Separate women's building | No | No | — | No | No | Yes | No | No | OB belongs in general hospital |
| 2 | Separate women's entrance | No | No | — | No | No | Yes | No | No | No separate OB entrance |
| 3 | Who prepares infants' formulas? | Dietary | Nursing | — | Dietary | — | Dietary | Nursing | Nursing | Inconclusive |
| 4 | Doctor examines infants outside nursery | — | Yes | — | Yes | — | — | Yes | — | This should be planned for |
| 5 | Combine hospital and O.-P. D. entrances | No | Yes | No | Yes | No | No | No | No | Desirable but difficult |
| 6 | Isolation unit in pediatrics O.-P. D. | Yes | Yes | No | Yes | — | Yes | Yes | Yes | Isolation unit essential |
| 7 | Combine hospital and O.-P. D. records | Yes | Yes | Yes | Yes | Yes | No | — | — | This should be done unquestionably |
| 8 | Microfilm records | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | All older than 20 years |
| 9 | Are pneumatic tubes desirable? | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Good for errands |
| 10 | Central sterile supply under whom? | Supt. | Supt. | Supt. | Supt. | — | Nursing | Nursing | Nursing | Put it under superintendent |
| 11 | Manufacturing pharmacy in hospital | No | No | Yes | No | No | School | No | No | This should be investigated |
| 12 | Centralize radiology | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Carry as far as possible |
| 13 | Centralize laboratories | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Carry as far as practical |
| 14 | Centralize linen supply | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Do this |
| 15 | Where store patients' clothing? | Rooms | Rooms | Rooms | Cen. | Cen. | — | Rooms | Rooms | Plan for storage in rooms |
| 16 | Type of food service | Bulk | Bulk | Bulk | Bulk | Bulk | Bulk | Bulk | Tray | Patient likes hot food |
| 17 | Chapel and religious care | No | No | No | No | No | No | Yes | Yes | Desirable feature |
| 18 | Use roofs for patients | No | Yes | No | Yes | No | No | Yes | No | Questionable |
| 19 | Hospital facilities in basement | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Necessary economy |
| 20 | Desirable size for nursing unit | 40 | 17 | 25 | 40 | 35 | 22 | 36 | 25 | It's anyone's guess |
| 21 | Large wards (12 or more) | No | Yes | No | No | No | Yes | No | No | No large wards |
| 22 | Visual aids and display | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | This is an unplowed field |
| 23 | Conference rooms for teaching | Yes | Yes | Yes | Yes | No | Yes | No | No | Essential |
| 24 | Preferred call system | Voice | Lights | Voice | Voice | Lights | Voice | Lights | Lights | No system is perfect |

of centralization and the benefits of dispersion.

### BASIC FACILITIES

In line with the general idea that medical service is to be broadened is the opinion that distribution of beds among the services, especially in teaching hospitals, should be more toward the main services of medicine, surgery, pediatrics and obstetrics and gynecology and less to the specialties. Similarly, the opinions expressed against separation of women's services indicate that the general hospital of the future will provide adequately for those basic services under one administration.

A general feeling was expressed that there would be a slight relative decrease of surgical beds and a shifting of pediatric service from hospitalization to out-patient treatment. No opinions were sought on questions of chronic diseases, tuberculosis, geriatrics and other specialties.

Care for mental disease cases was still thought better provided outside the general hospital but, if possible, adjoining it. Similarly, it was felt that the specialties, tuberculosis, chronic and communicable diseases will continue to require separate housing, preferably as units in the medical center.

### HOSPITAL PLANS

Much has been written on the growing importance of plans for hospital care. It is enough to note here that opinion is strong for reducing the size of wards and increasing the number of private and semiprivate rooms and also the total number of beds to take care of anticipated demands.

It is not thought that the length of patient stay will be increased and, in fact, earlier hospitalization upon removal of economic restraint may actually reduce the length of stay. Other influences felt were the increasing importance of out-patient service and its future importance if plans for hospital care eventually lead into plans for medical care also.

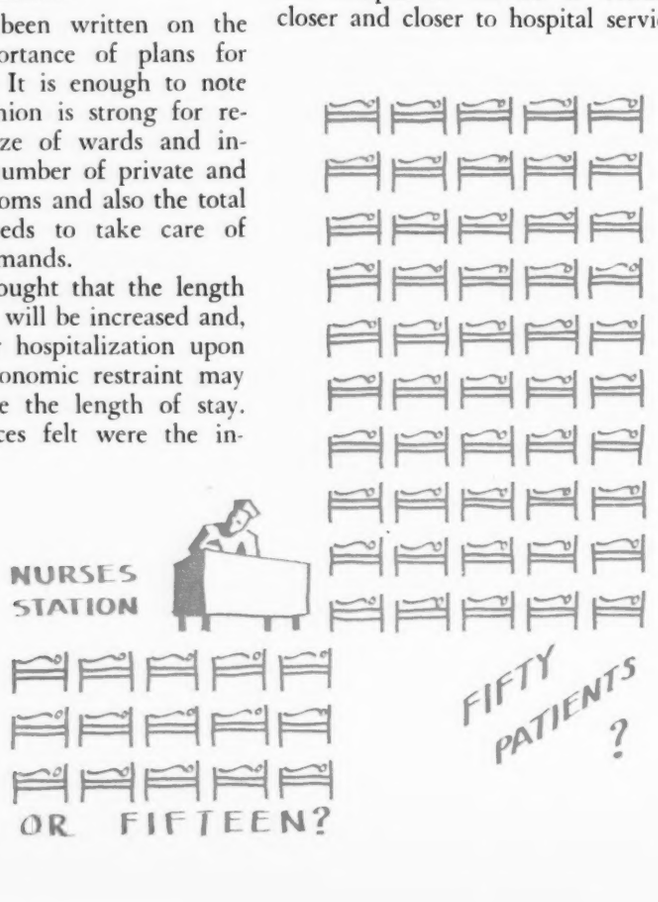
### PUBLIC RELATIONS

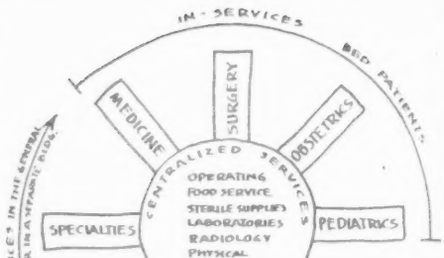
This field, like visual education, seems almost unentered. Without going into the detailed problems involved we can record only a complete lack of unanimity in the opinions expressed. They range from the feeling that it is unprofessional to tell about the hospital's work to the conviction that the public must be told the daily drama of the house of healing, but few consistent plans have been set up to do this.

As might be expected, the high quality of hospital personnel results in good public relations wherever there is contact, but too often that contact is hurried or inopportune or under too much stress to educate the public and obtain its support. There should be much more sharing of experience and ideas in this area.

### OUT-PATIENT DEPARTMENT

As might be expected, marked decreases were noted during the war in free out-patient services, with increases in income where the system permitted partial payment and equivalent large increases in attendance at the private clinics. In many ways the out-patient service is coming closer and closer to hospital service,




following the general trend toward broadening medical care.

Home extension services in general are limited but there seems to be agreement that as curative and preventive services draw closer together more of what has been exclusively hospital treatment will get out into the homes at the same time that preventive teaching reduces the load on the hospitals.

It is encouraging to hear the opinion expressed that some day there may be no sharp distinction between preventive measures, public health measures, out-patient service and hospital care, but only care for the patient.

### PLANNING RELATIONSHIPS

The table indicates that most of the questions asked were about specific functional relationships. Such information is essential to satisfactory planning.

### SIZE OF NURSING UNITS

Great variety of opinion was expressed on this point. The majority believes that the trend is toward larger units of about 40 beds per station for economy of supervision, with service made easier by having subutility rooms at several locations within the unit. Breaking up large wards was advocated if only with partitions of door height. Draw curtains to surround each bed were considered essential.

### TEACHING REQUIREMENTS

A volume could be written about the special needs for clinical teaching. The general opinion is that teaching is an accepted part of good medical service and that it will continue to be an important factor in measuring the quality of a hospital. In planning for the clinical teaching

the obvious requirements include larger examining rooms, offices for clinical staff, space at the nurses' station for study of records, special research laboratories on the hospital floor and a conference room equipped for movies, radio, television, microfilm, museum material and books. Student locker rooms and lecture rooms are usually in the school buildings but may be in the hospital. Careful study should be given the numerical ratio of students to patients in all planning for medical education.

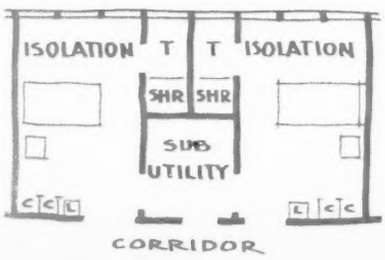
## CENTRALIZATION

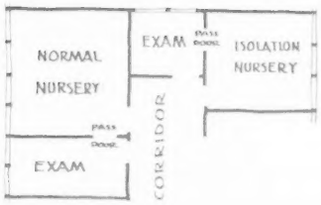
Help shortages have made us acutely conscious of all possible service economies. One such economy comes through centralization of adjunct services, which may include combining out-patient and hospital records; centralizing laboratories; centralizing radiology; establishing a central kitchen with either bulk service to floor kitchens or tray service to floors; having all receiving and stores at one point; establishing central sterile supply; combining electrotherapy, hydrotherapy, massage and occupational therapy into one physical therapy unit; combining out-patient department and hospital entrances, and centralizing all operating rooms.

The resultant gain in efficiency is marked, up to a point, but falls off when the process begins to remove from the nursing units facilities which are needed frequently or at unscheduled times. It will be found, also, that adequate teaching facilities often prevent the most economical centralization, in which case the more important requirements must be met. A balance point in the process can be found, but the opinion is that much more centralization is currently needed and can be obtained without loss of economy and convenience.

## ISOLATION

Administrators are quite conscious of isolation requirements. In each




general nursing unit a room or pair of rooms with adjoining toilet and subutility room is thought essential. In obstetrics a complete isolation delivery unit is desirable, containing approximately one eighth of the total obstetrical beds. In this unit doctors and nurses observe full isolation technics.

An isolation nursery is essential and should contain about one sixth of the total number of bassinets. It is also desirable to isolate the doctor from infants by providing an examining room adjoining the nursery so that he need not enter the nursery himself. In pediatrics there is need for a room equipped to maintain high humidities for chest cases. The pediatrics out-patient unit should have an isolation examining room for screening communicable disease suspects. Isolation of surgical cases for special care immediately following operation calls for recovery beds adjoining the operating rooms, and all nursing units should have at least two single rooms for the critically ill.

## RESIDENTS' QUARTERS

Concern was expressed by all administrators over insufficient housing for residents, and the expectation is that more quarters for married doctors and students should be provided. The general opinion is that space near the hospital would serve as well as would housing within the actual building.

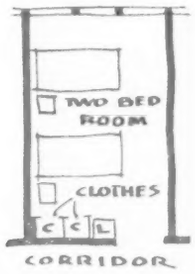
## AIDS TO SERVICE

A few comments might be made on certain detailed questions.

*Call Systems:* No system is perfect and whatever is put in will be disliked by some. In general, the light system seems more satisfactory for smaller hospitals and the speaker system (well modulated) for the larger. The bell system is not considered good.

*Use of Basement:* Administrators like the idea of restricting the basement to service use and eliminating all patients and professional staff from it, but they feel that that is probably a luxury which can be afforded by few hospitals and that kitchen, dining rooms, laundry, locker rooms, stores, records and pharmacy may have to be put below the first floor.

*Patients' Clothes:* Opinion was mixed but the trend was all in favor of providing for patients' clothes in the bedrooms and eliminating central clothes storage.

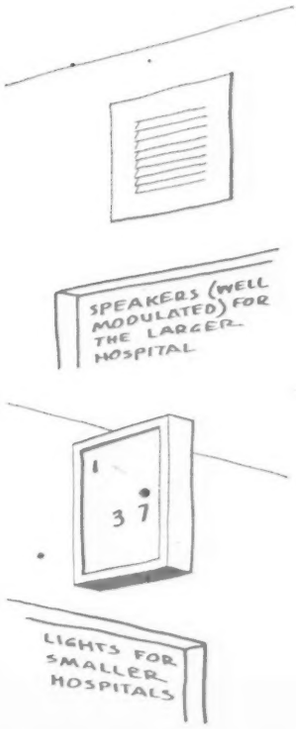



*Linen:* This service should be centralized. One administrator had worked out a linen cart which could circulate on the floors and supply all needed linen daily, eliminating most of the floor inventory and preventing hoarding.

*Pharmacy:* Opinion was that the pharmacy needs study to see whether manufacturing, compounding and dispensing cannot be worked out efficiently and economically for a moderate sized hospital.

*Central Supply:* Opinion was that it works better when it is directly controlled by the administrator.

*Pneumatic Tubes:* These are good for messages and emergency records,



but dumb-waiters and carts must still be used for many things.

*Records:* Opinion, based on long years of experience, was strongly in favor of combining out-patient and hospital records. Microfilming was accepted for records older than twenty years but, thus far, teaching requirements make it seem difficult to do away with physical records more recent than that. One administrator strongly favored filing old records vertically on shelves like books instead of in file drawers as a method of saving space and equipment.

*Uniformity:* It was suggested that in planning new hospitals common units, such as the nursing station, utility room, routine laboratory, serving kitchen, narcotics cabinet and examining room, be made exactly alike so that personnel would be familiar with every detail of arrangement no matter what the station. This principle is applied successfully by the Navy on shipboard.

*Waiting Space:* Get it out of the corridors and traffic areas and make the space cheerful, comfortable and close to the call station.

## OPERATING ROOMS

So many questions about planning an operating room remain unanswered that it seemed outside the scope of this article to cover them. The excellent reference list by Dr. S. S. Goldwater, which appeared in The Modern Hospital for November 1931, will stimulate thinking on this subject.

It is worth noting, however, that while it appears to be generally agreed that there should be fewer operating rooms and more operations per room per year, there is still no general agreement on the following points: size of rooms; number of rooms per thousand operations per year; separate anesthetizing rooms; central or local scrub-up or scrub-up in operating rooms; central or local sterilizing or both; extent of air conditioning; control of static electricity; steam or water sterilizers for instruments; floor material; wall material; acoustical tile; lighting, general and specific; colors; germicidal lamps; observation galleries; windows or no windows; central instrument service; blanket and solution warmers; movies and television; a postoperative recovery ward.

It is obvious that this is one of the special problems that will take the careful and detailed study of all concerned.

## MATERIALS AND CONSTRUCTION

No detailed survey was made of existing conditions or opinions in this area. General discussion and observation, however, permit some conclusions to be made. They are as follows:

**Floors:**
- Concrete in service areas.
- Rubber tile in corridors.
- Ceramic tile in utility spaces.
- Terrazzo in operating rooms.
- Asphalt tile in other finished spaces.

**Walls:**
- Plaster on clay or gypsum tile.
- Office type of partitions where possible.
- Ceramic tile in operating rooms.
- Terra cotta wainscot in corridors.
- Washable wall coverings desirable.
- Use color advisedly.

**Ceilings:**
- Plaster in general.
- More acoustical tile.

**Windows:**
- Wood double hung.

**Air Conditioning:**
- Still expensive but desirable.

**Lighting:**
- Think of the patient.
- Germicidal lamps gaining.

**Utilities:**
- Simplify and centralize. Plan carefully for maintenance and expansion.

**Maintenance:**
- Examine every element of construction and finish for its maintenance cost as well as original cost. The two combined make its actual cost. Provide space for maintenance and operation.

It should be recognized that opinions based on experience are likely to be conservative. No comments were made on the whole field of plastic materials (including glass) which may become more widely accepted for wall coverings, trim, floors, windows, doors and equipment. It seems probable that the use of stainless steel and other such metals will be greatly stimulated and that many improvements in lighting and mechanical services will be made. This is a field for investigation that has not been attempted here.

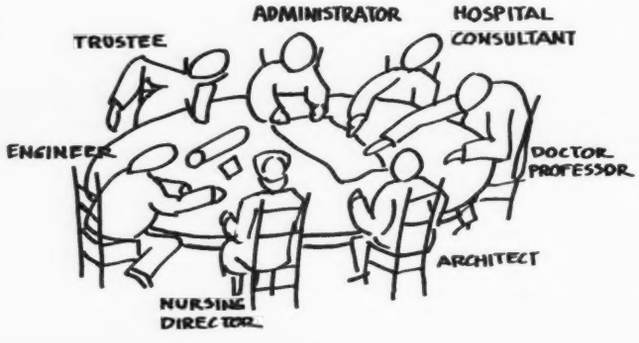
## MAINTENANCE

It is worth special mention that administrators are keenly aware of maintenance problems as they relate to both materials and space. The time is past when the original cost of a material is thought of as its only cost and when the mechanical services are put in as an afterthought. Today, the trend in hospital planning is clearly toward providing a structural shell and a well-planned mechanical framework into which can be put the necessary hospital facilities.

Specifically, this means permanent space for circulation (corridors, elevators and stairs) and for janitor service and for mechanical equipment; arrangement of facilities for maximum economy of utilities; continuity of floor, wall and ceiling surfaces wherever possible; selection of materials for ease of maintenance, and, above all, repeated counsel during planning from those who are going to operate and maintain the building. This may seem obvious and elementary but it is a practice which has not always been followed in planning hospitals.

## CONCLUSION

The final and most significant conclusion is that hospital administrators, hospital consultants and architects need to get together regularly to share ideas and experiences on this important question of hospital planning.



## THE SMALL HOSPITAL

# FORTY BEDS—*Expansion to Sixty*

***This plan of a 40 bed hospital which can be expanded to 60 beds was submitted in The Modern Hospital architectural contest last year. The explanation by the architects, John T. Grisdale and J. Roy Carroll Jr., the editors' comment and the plans are reproduced from "The Modern Small Hospital," a compilation of the outstanding entries submitted in the contest***

### *Architects' Statement*

THIS hospital is to be located in a town between Philadelphia and Lancaster, Pa., with a population of 4702. It has hot, humid summers and moderately cold winters, with little snow.

The average temperature from October 1 to May 1 is 42°F. The average temperature from May 1 to October 1 is 67°F. The summer wind is southwest at a speed of 9.7 m.p.h. on the average while the winter wind is northwest at 11 m.p.h. The desirable exposure is south southwest.

The country is rolling farmland with small wooded areas.

The region has a prosperous farming area and a few small industrial sections. Most persons could afford and would desire private or semi-private rooms. There are many large families.

### *Editors' Comment*

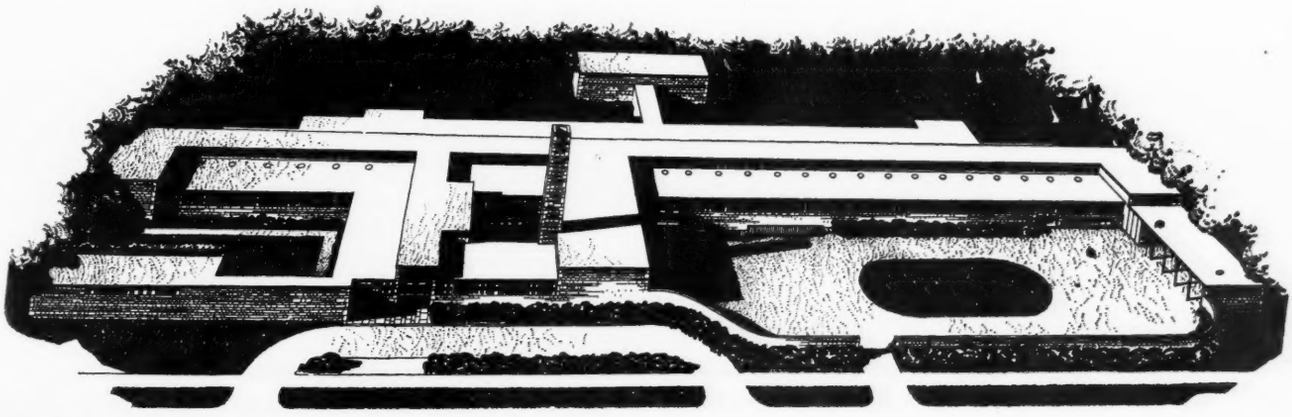
THIS is a carefully worked out, double corridor plan with clerestory over the central unit to provide light and air. Such an arrangement would appear to be quite feasible for a one story hospital, although much more difficult to use in a multistoried building.

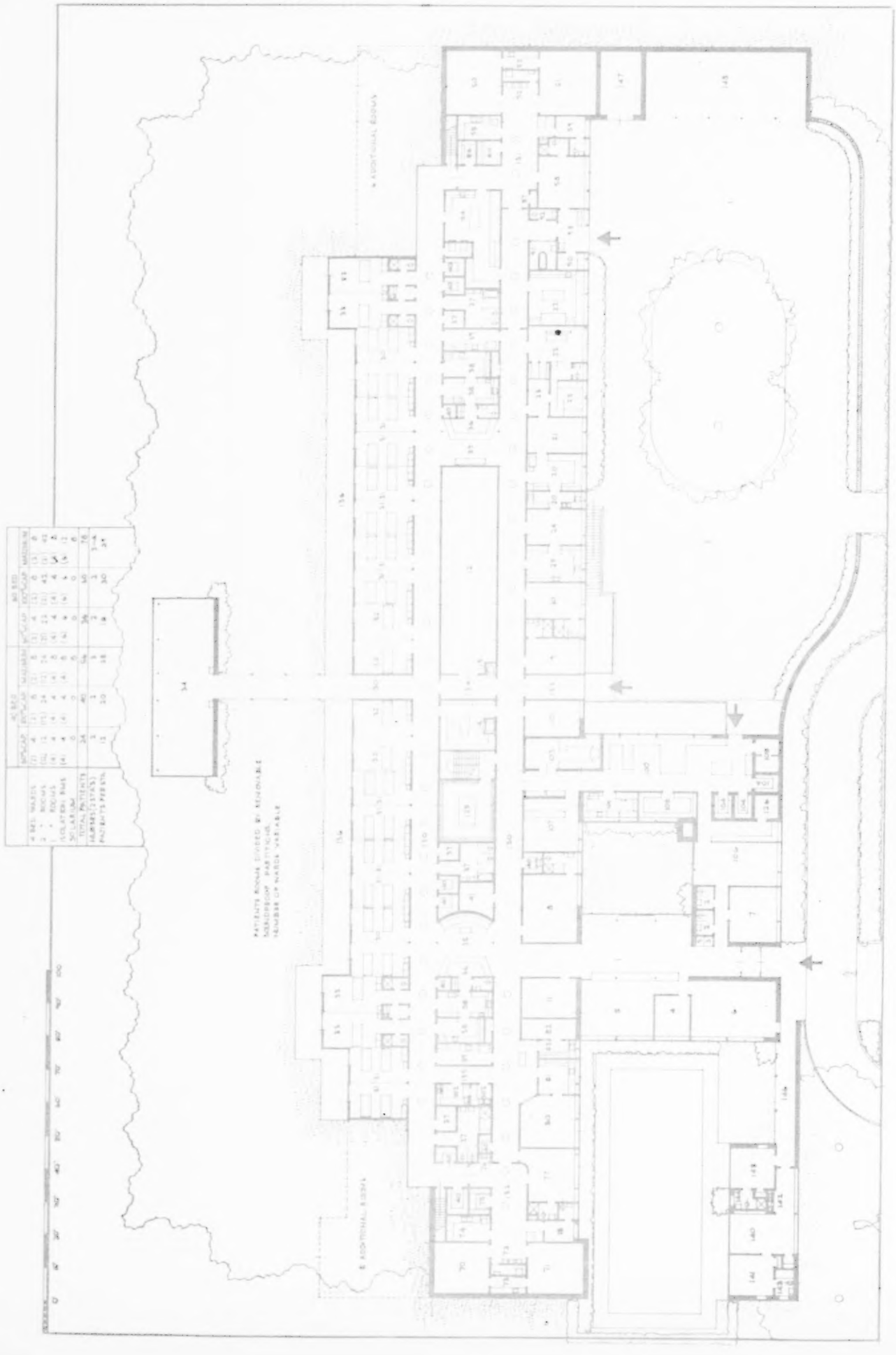
Including the isolation rooms, this plan has eight beds in private rooms, eight in four bed wards and 24 in two bed rooms, a good distribution. The four bed rooms can easily be divided into two two bed rooms each. The single rooms are also large enough for two beds; with eight beds in the solarium, the 40 bed hospital thus has an emergency capacity of 56 beds. (Incidentally it would be difficult to nurse the eight patients in the solarium since it is a long way from either of the nursing stations. The solarium would be more useful if incorporated in the building.)

The control of visitors has been carefully worked out. There is good segregation of services, with obstetrics and surgery at opposite ends of the building. (This makes common use of sterilizers more difficult, however.) All patients' rooms are on the south, extremely well shielded from the service entrances and the busiest areas of the hospital. Even the corridors in front of patients' rooms would be relieved of much traffic, making this a hospital in which patients could really obtain rest and sleep if the nursing staff is willing to organize its work to permit patients to sleep.

Attractive quarters for the administrator and the salaried house officer are provided, with a pool or sunken garden between their quarters and the east end of the hospital.

The various diagrammatic presentations show how carefully and how well the plan has been studied. There are a large laundry, ample lounge space for employes and generous storage and other facilities. As a result, the volume of the 40 bed hospital (416,000 cubic feet given by the architect) is high. But enlargement by the addition of 11 more rooms to bring the normal capacity



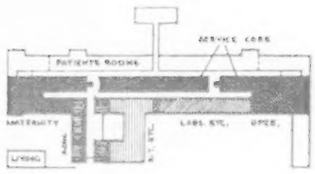


| ROOM NO. | NAME | SIZE | 40 BED | MACDONALD & SHAFFER 50 BED | 60 BED |
|---|---|---|---|---|---|
| OBSTETRICS SUITE CONT. | | | | | |
| 77 | DRS. RM. | 13.5X15.5+ | 235 | 175 | |
| 78 | NRS. RM. | SEE 8 | 115 | 50 | |
| | TOTAL | | 1165 | 965 | 1165 |
| | PER BED | | 29.1 | 19.3 | 19.4 |
| NURSERY | | | | | |
| 80 | NURSERY | 15.5X16.5 | 256 | 240 | |
| 81 | WORKSPACE | 10.5X11 | 116 | 125 | |
| 82 | SUSPECT N. | 6 X 16.5 | 99 | 80 | |
| 83 | WORKSPACE | 5.5X11 | 61 | 40 | |
| | TOTAL | | 532 | 485 | 532 |
| | PER BED | | 13.3 | 9.7 | 8.9 |
| EMERGENCY | | | | | |
| 90 | WAITING | 5 X 8 | 40 | | |
| 91 | BATH | 9 X 8 | 72 | 60 | |
| 92 | TOILET | 3 X 8 | 24 | 20 | |
| | SUPPLIES | SEE 56 | | 65 | |
| | STRETCHER | WITH 93 | | 35 | |
| | EMER.OPER | SEE 51 | | | |
| 93 | EMER.VEST | IRREG. | 158 | | |
| | TOTAL | | 294 | 180 | 294 |
| | PER BED | | 7.3 | 3.6 | 4.9 |
| DIETARY DEPT. | | | | | |
| 100 | MAIN K. | IRREG. | 1062 | 1200 | |
| 101 | DIET K | 8 X 16 | 128 | 140 | |
| 102 | FORMULA K. | NEAR 80 | 100 | 100 | |
| 103 | DISHWASHING | 22.5X9 | 203 | 120 | |
| 104 | REFRIG. | | 105 | 90 | |
| | FOOD ST. | | | | |
| 105 | GARBAGE | | 70 | 70 | |
| 106 | STAFF DIN. | 19.5 X 24 | 468 | 310 | |
| 107 | HELP DIN. | 16X16.5 | 264 | 210 | |
| 108 | DRY STORES | | 150 | 100 | |
| | TOTAL | | 2550 | 2340 | 2550 |
| | PER BED. | | 63.9 | 46.8 | 42.6 |

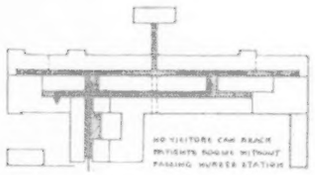
| ROOM NO. | NAME | SIZE | 40 BED | MACDONALD & SHAFFER 50 BED | 60 BED. |
|---|---|---|---|---|---|
| HOUSEKEEPING DEPT. | | | | | |
| 110 | HSKPR. OFF. | 11 X 16.5 | 182 | 110 | |
| 111 | CENT. LINEN | 15X 16.5 | 248 | 190 | |
| 112 | LAUNDRY & SOILED LIN. | | 950 | 800 | |
| | | | | 140 | |
| 113 | TOILET | 5 X 6 | 30 | | |
| 114 | DUMB-WTR. | | | | |
| 115 | CLOTHES CH. | | | | |
| | TOTAL | | 1410 | 1240 | 1410 |
| | PER BED | | 35.3 | 24.8 | 23.5 |
| MECHANICAL DEPT. | | | | | |
| 120 | BOILER ETC. | | 984 | 900 | |
| 121 | OFF & SHOP | | 362 | 130 | |
| 122 | TRANSF'R. | 10 X 14 | 140 | | |
| 123 | TOILET | 5 X 8 | 40 | | |
| 124 | FUEL | 8 X 24 | 192 | | |
| 125 | EVAP. COND. | 16.5 X 18.5 | 305 | | |
| 126 | REFR.MACH. | 7 X 7 | 49 | | |
| | TOTAL | | 2072 | 1030 | 2072 |
| | PER BED | | 51.8 | 20.6 | 34.5 |
| 130 | CORRIDOR | 8'WIDE | | | |
| 131 | OPER. CORR. | 10.5'WIDE | | | |
| 132 | OB. CORR. | 10.5'WIDE | | | |
| 133 | SERV. ENT. | 8'WIDE | | | |
| 134 | SERV. CORR. | 8'WIDE | | | |
| 135 | NURSERY COR. | 5'WIDE | | | |
| 140 | ADM. L.R. | 12 X 19+ | 298 | | |
| 141 | " B.R. | 12 X 13 | 156 | | |
| 142 | " K. | 2 X 7 | 14 | | |
| 143 | " BATH | 5 X 8 | 40 | | |
| 144 | S.H.O. BATH | IRREG. | 45 | | |
| 145 | " B.R. | 12 X 13 | 156 | | |
| 146 | PORCH | 30 X 6 | 180 | | |
| 147 | GARDENER | 12 X 19 | 228 | | |
| 148 | CAR SHED | 48 X 20 | 960 | | |

| ROOM NO. | NAME | SIZE | 40 BED | MACDONALD & SHAFFER 50 BED | 60 BED |
|---|---|---|---|---|---|
| ADMINISTRATION | | | | | |
| 1 | LOBBY | 19 X 33 | 627 | 320 | |
| 2 | PUB.TOILET | 5 X 7 2 | 70 | 90 | |
| 3 | " TEL. | 3 X 5 | 15 | 10 | |
| | ADMITTING. | SEE 4 | | 150 | |
| | INFO. | WITH 5 | | 90 | |
| 4 | ADMNSTR. | 11 X 12 | 132 | 160 | |
| | SEC. | WITH 8 | | 125 | |
| 5 | BUS. OFF. | 16.5 X 22 | 363 | 250 | |
| | TOILETS | SEE 2 | | 90 | |
| 6 | RECORDS | 16.5X25 | 412 | 200 | |
| | DIR.OFNRS. | SEE 4 | | 140 | |
| 7 | STAFF | 14.5X16.5 | 240 | 250 | |
| | LIBRARY | WITH 6 | | | |
| | TOTAL | | 1859 | 1875 | 1859 |
| | PER BED | | 46.5 | 37.5 | 30.9 |
| EMPLOYEES FACILITIES | | | | | |
| 8 | NURSES RM. | 16.5X 20+ | 390 | 320 | |
| 9 | MENS RM. | 10.5X 16.5+ | 217 | 130 | |
| 10 | WOMENS RM | 10.5X 16.5+ | 217 | 130 | |
| | TOTAL | | 824 | 580 | 1859 |
| | PER BED | | 20.6 | 11.6 | 13.7 |
| STORAGE | | | | | |
| 11 | RECORDS | 11.5 X 16.5 | 190 | 175 | |
| 12 | CENTRAL | 16.5X 62 | 1023 | 1000 | |
| | TOTAL | | 1213 | 1175 | 1213 |
| | PER BED | | 30.3 | 23.5 | 22.1 |
| ADJUNCT SERVICES | | | | | |
| 20 | PATH. LAB. | 16.5X 16.5 | 263 | 250 | |
| 21 | OFFICE | 10.5X 16.5 | 173 | | |
| 22 | MORGUE | 16.5X 16.5 | 263 | 250 | |
| 23 | RADIOLOGY | 16.5X 27 | 445 | 400 | |
| 24 | B.M. ETC. | 10.5X 16.5 | 173 | 160 | |
| 25 | PHARMACY | 11 X 16.5 | 181 | 185 | |
| | TOTAL | | 1498 | 1245 | 1498 |
| | PER BED | | 37.4 | 24.9 | 24.9 |

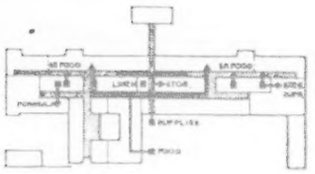
| ROOM NO. | NAME | SIZE | 40 BED | MACDONALD & SHAFFER 50 BED | 60 BED |
|---|---|---|---|---|---|
| PATIENT AREAS | | | | | |
| 30 | 4 BED W.(2) | 16.5X 20.8 | 712 | | 712 |
| 31 | 2 " R(12) | 16.5X 10.3 | 2040 | | 3570 |
| 32 | 1 " R(4) | 16.5X 10.3 | 680 | | 1680 |
| 33 | 1 " 150. (4) | 24.5X 10.3 | 1010 | | 1514 |
| 34 | SOLARIUM | 18 X 53 | 954 | 800 | 954 |
| 35 | VISITORS | VARIES | 162 | 130 | 162 |
| 36 | N. STA. (2) | " | 284 | 300 | 284 |
| 37 | B.P. & BATH(3) | IRREG. | 541 | 320 | 540 |
| 38 | UTIL. AREA(2) | IRREG. | 458 | 290 | 458 |
| 39 | PANTRY (2) | 16.5X 7 | 232 | 240 | 232 |
| 40 | CLOSETS | VARY | 233 | 260 | 238 |
| 41 | STRETCHERS | | 100 | | 100 |
| | TOTAL | | 7406 | 8740 | 9440 |
| | PER BED | | 185.1 | 174.8 | 157.3 |
| OPERATING SUITE | | | | | |
| 50 | MAJOR OR | 16.5X 19 | 314 | 310 | |
| 51 | MINOR OR | 16.5X 19 | 314 | 260 | |
| 52 | SCRUB-UP | 4.8X 10.5 | 50 | 50 | |
| 53 | SUB-STER. | 9 X 10.5 | 95 | 100 | |
| 54 | CENT. STER | IRREG | 420 | 400 | |
| 55 | UTILITY | 7.5X 13 | 98 | 125 | |
| 56 | STORAGE | 7.5X 5 | 38 | 70 | |
| 57 | JANITOR | 2.5X 5.5 | 14 | 20 | |
| 58 | DRS. RM. | 13.5X15.5+ | 235 | 240 | |
| 59 | NRS. RM. | SEE 8 | 115 | 160 | |
| 60 | ANESTHETKS | 7.5X 7.5 | 56 | 110 | |
| | TOTAL | | 1743 | 1845 | 1743 |
| | PER BED | | 43.6 | 36.9 | 29.1 |
| OBSTETRICS SUITE | | | | | |
| 70 | DELIVERY | 16 X 16.6 | 248 | 225 | |
| 71 | LABOR | 15X 16.6 | 248 | 180 | |
| 72 | SCRUB UP | 4.8X 10.5 | 50 | 50 | |
| 73 | SUB-STER. | 10X 10.5 | 105 | 100 | |
| 74 | UTILITY | 8 X 13 | 104 | 125 | |
| 75 | SUPPLIES | 6 X 8 | 48 | 40 | |
| 76 | JANITOR | 3 X 4 | 12 | 20 | |



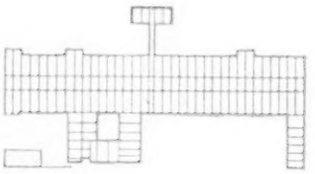
HOSPITAL DIVISIONS

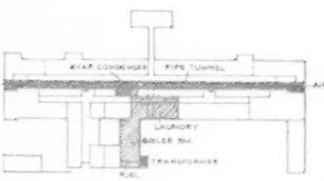


CIRCULATION ~ VISITORS

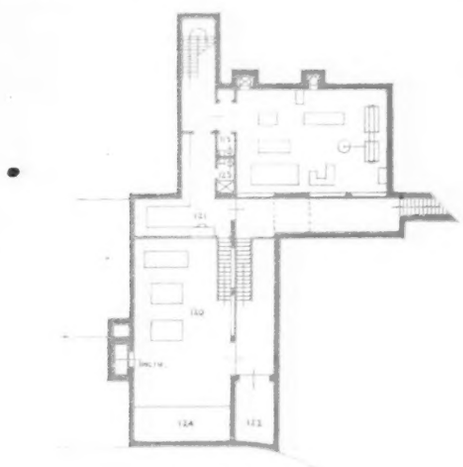


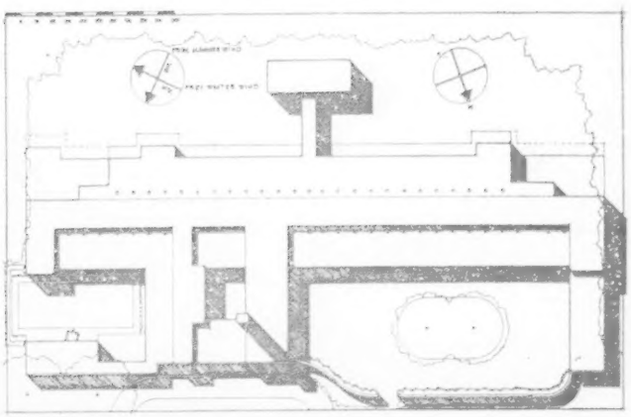
CIRCULATION ~ SERVICE


STRUCTURAL PATTERN



UTILITIES LOCATIONS ~


BASEMENT PLAN



to 60 beds and the emergency capacity to 78 beds would be simple and inexpensive and would bring the volume down from 10,400 cubic feet per bed (normal capacity) to 7450 cubic feet. The loose sprawling plan will, of course, be expensive to build.

The two nursing stations are so arranged that nurses do not have far to go to reach patients and even with the enlarged capacity could serve all patients adequately.

Presumably the entire building will be air conditioned. Altogether, this is a carefully and intelligently planned hospital with many commendable features.

**Opposite Page: Plan of the proposed hospital and (above) key showing space allotted to various areas in 40, 50 and 60 bed hospital. Right: The basement plan and the plot plan.**

## 1500 BEDS

**THOMAS F. ELLERBE**

Ellerbe and Company
Architects and Engineers
St. Paul, Minn.

# MULTISTORY
## *Favored for Large Hospital*

THE new Kahler Hospital at Rochester, Minn., will be an addition to the existing properties of the Kahler Corporation, which include other hospital facilities, hotels and such service units as a laundry and central heating plant.

Roy Watson, president of the corporation, requested that in planning the building efficiency in operation be the paramount consideration. At no time was there any compromise in planning that would reduce the quality of service rendered; on the contrary, this demand for efficiency always resulted in rendering better care to the patient. The medical staff of this hospital is the medical staff of the Mayo Clinic. The nursing staff is supplemented by student nurses from the Kahler School of Nursing.

### First Unit 800 Beds

The hospital is designed for an ultimate capacity of about 1500 beds and is to cover an entire city block. The first half of the building to be built presently will contain 800 beds and will cover half the city block. The present and future typical floors will contain two complete self-contained administrative units. The only facilities for the typical floors that will have common use will be the elevators.

Considerable thought was given to the multi-storied plan *versus* the pavilion plan. The conditions in favor of the vertical multi-storied building far outweighed the advantages of the pavilion type. The first half of the building has 13 bedroom floors which are laid out in the form of a cross. The bedroom floors are superimposed on four floors covering half of the entire ground area of a city block and housing non-bed facilities, such as administration, patient admissions, stockroom and receiving room on the first floor; kitchens and dining rooms on the second floor; surgery on the third floor; laboratories on the fourth floor.

### Viewing Gallery on Fourth Floor

The fourth floor is a mezzanine floor allowing greater height for the operating rooms below. Access to the view stands in the operating rooms is from this level. The portion of this floor that is not occupied by the operating rooms is assigned to routine laboratories. The two top floors, 18 and 19, are used for resident fellows' quarters. These two floors do not cover the entire area of a bedroom floor. Above these floors the elevator equipment and water tanks are housed.

All 13 bedroom floors are essentially the same. The typical floor accommodates 62 beds in one, two and four bed rooms. Of the 28 single units, four are de luxe rooms with bath. Thirteen two bed rooms and two four bed wards provide the additional 34 beds. The medical and surgical services assigned to this unit may vary from time to time owing to the fact that other hospital units will provide approximately 800 beds. No provision is made for obstetrics. Provision for pediatrics is made to the extent that the children admitted on any surgical service are cared for in the pediatrics division.

The administration of the hospital is satisfied, after many years of experience in operating nursing units of various sizes, that the best results from the standpoints of patient care and economy of operation can be obtained if the nursing unit has approximately 60 beds. This number is somewhat larger than is commonly used. In order to accommodate this number of beds without involving excessive distances, the cross type of plan was the obvious answer.

Each bedroom is to have its own toilet room. These toilet rooms are equipped with a water closet having bedpan lugs and spray washers, a lavatory and a bedpan cabinet. This toilet room is considered more in the light of a subutility room for the nurse's use in the care of the patient than as an added accommodation for the patient.

In making rounds, the procedure dictated by the medical staff requires that the charts should be in the patient's room a large part of the time. A closed chart cabinet accommodating the charts for two rooms will be placed in the corridor between these two rooms. These three considerations (short wings afforded by the cross plan, equipment for the personal care of the patient at each room and facilities for handling charts at each room) go a long way to overcome the objections to larger nursing units.

The various service functions on the typical floor are located at the crossing of the two wings. The housekeeping functions are conceived to include handling of flowers and the sterilization of utensils after the dismissal of the patient. This work is done in the housekeeping room. The utility room thus automatically becomes a clean utility room.

### Central Supply Established

The central supply service is located in the basement and the materials will be sent to the floors on three dumb-waiters. Two of these are large and one is small. These dumb-waiters land at each floor at the nurses' station. It is planned that all sterilization of supplies used on the floors, except bedpans, will be handled at central supply. Each floor will carry a small stock of certain sterile and other supplies which will be routinely replenished from central supply.

In order to obtain maximum efficiency from the elevators by diversity of use, all elevators are located in one bank. This bank is located in the center between the present and the future units.

The multi-storied building is ideally

suited for central tray service. The trays are completely set up on the service lines in the kitchen and carried to the floors on high-speed dumb-waiters. The location of the service rooms on the floors entails minimum walking when the trays are served. The trays are returned to the dishwashing room on a continuous vertical conveyor that automatically discharges them into the dishwashing room.

The kitchen is located on the second floor immediately above the receiving room. The receiving room and storeroom receive all food supplies and the main storage refrigerators are under the control of the storeroom from which daily supplies are issued to the kitchen. When the second half of the building is completed, the tray service lines and dumb-waiters will be duplicated for that portion of the hospital. The food preparation area is so located that when the future addition is erected, it will be centrally located between the two tray service lines.

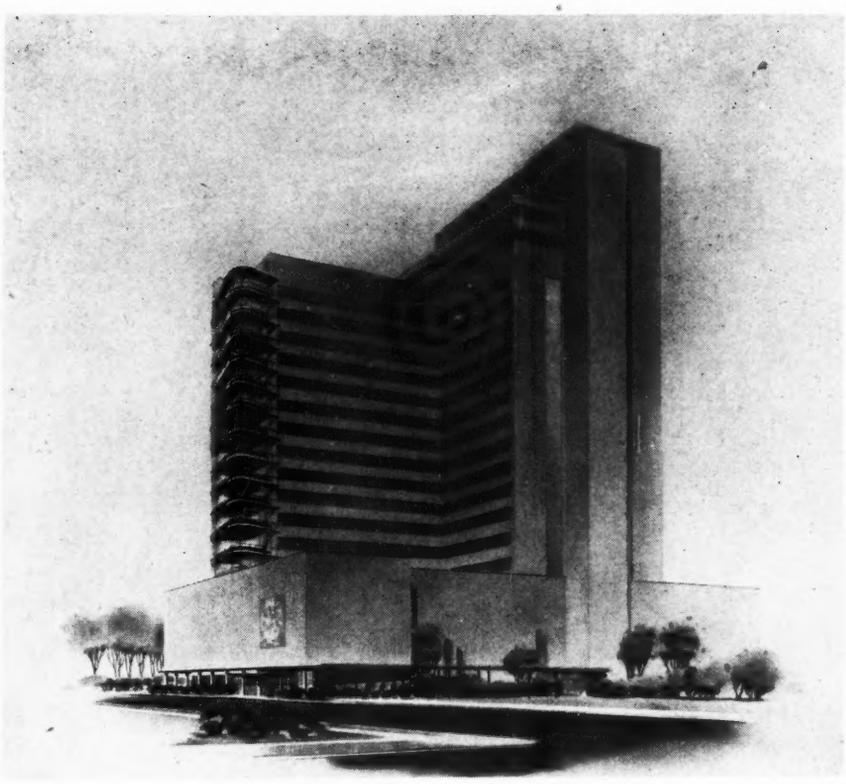
### 20 Operating Rooms

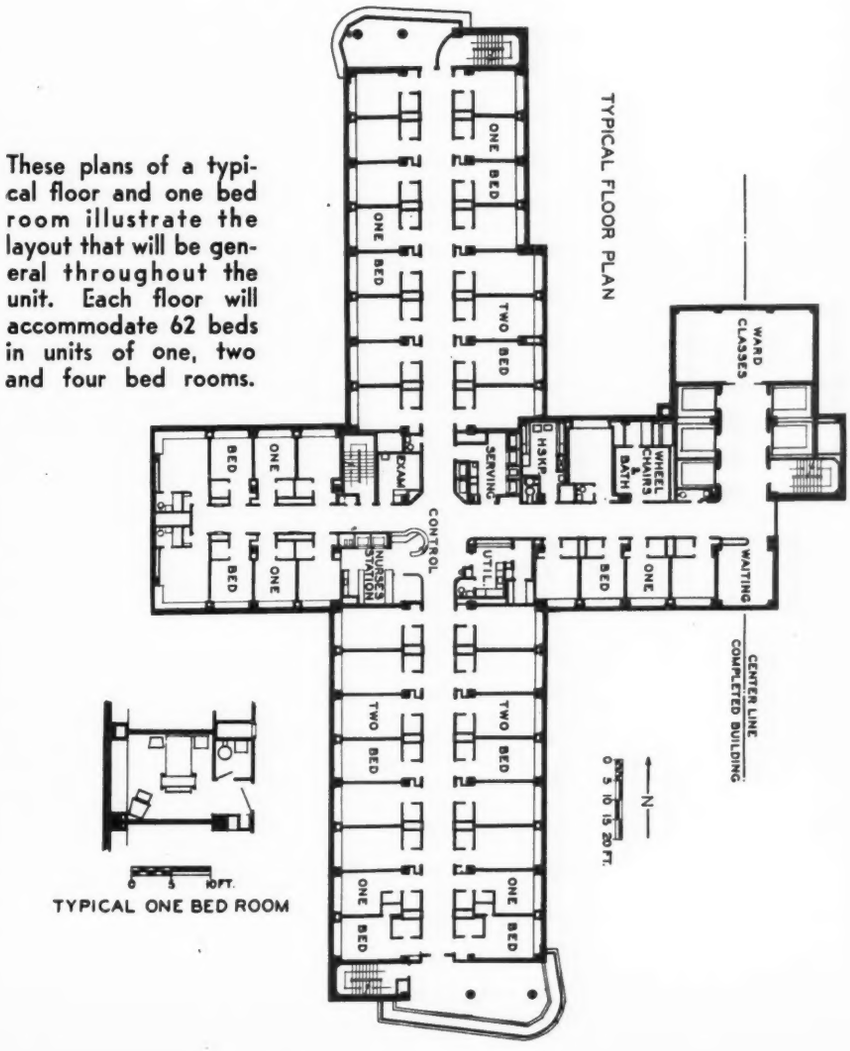
Various types of surgery, both general and special, will be done in the operating rooms. The fact that the type and volume of surgery may change from time to time suggested that operating rooms should be typical. Therefore, 16 operating rooms of similar size are provided; in addition, there are four considerably larger surgeries to accommodate the larger equipment used in orthopedic and neurosurgery. Two of these large operating rooms have plaster rooms adjoining so that it will be possible to move the table into the plaster room while the cast is being applied.

Special services required for some types of surgery, such as suction, direct current and low voltage current, are provided in the rooms assigned to special surgery; however, conduits and openings are provided so that the future installation of these services can be accomplished in all rooms. The lighting scheme has not been determined because new developments in this field are anticipated.

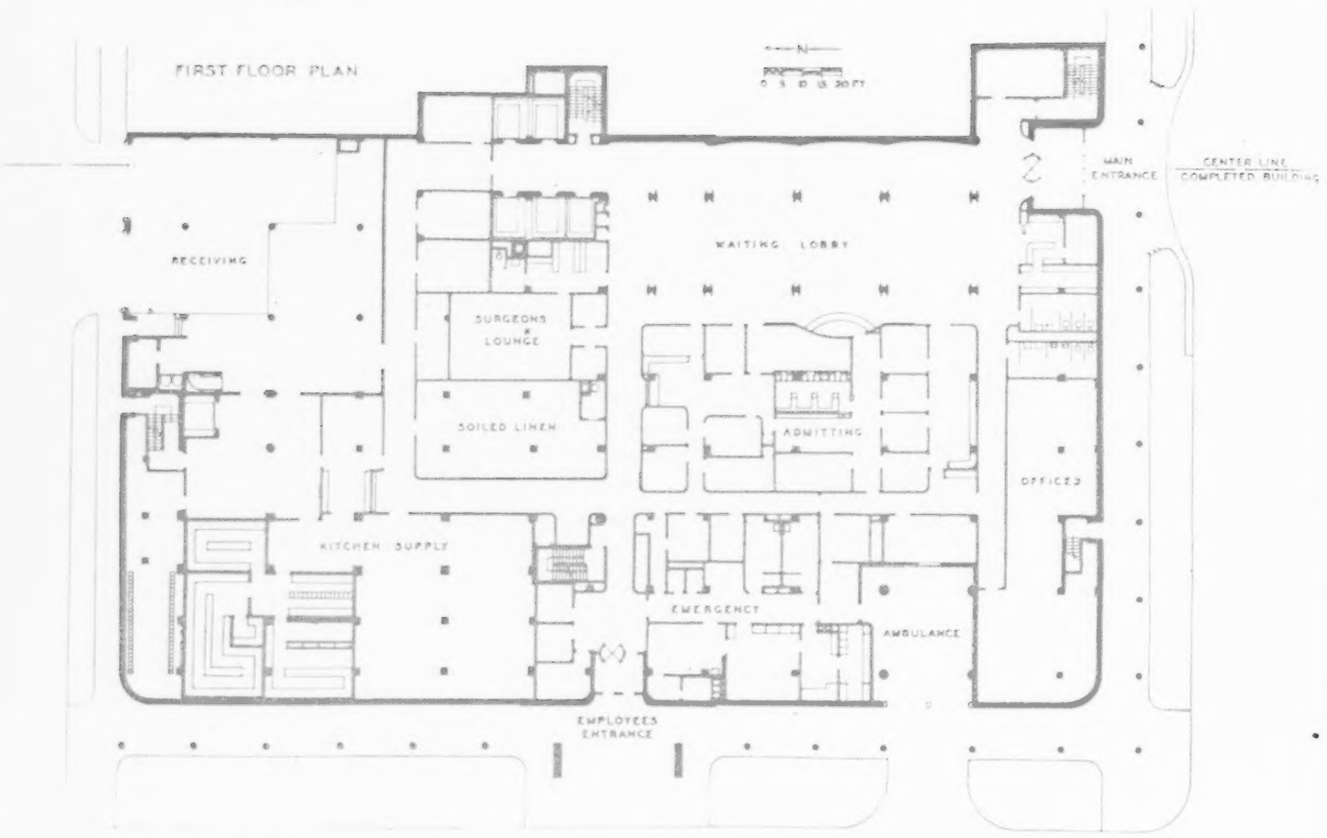
The two major supporting services required in surgery (surgical pathology and anesthesia) are located approximately in the center of the entire group of operating rooms. The surgeons generally occupy two rooms

(*Continued on Page* 56.)



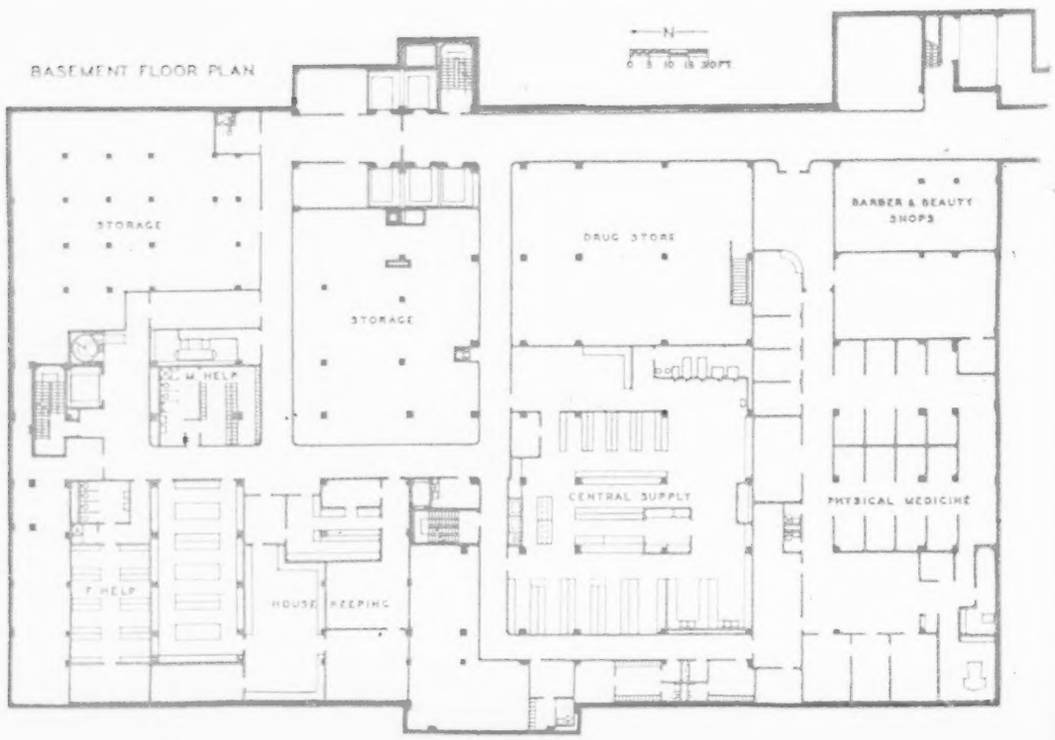


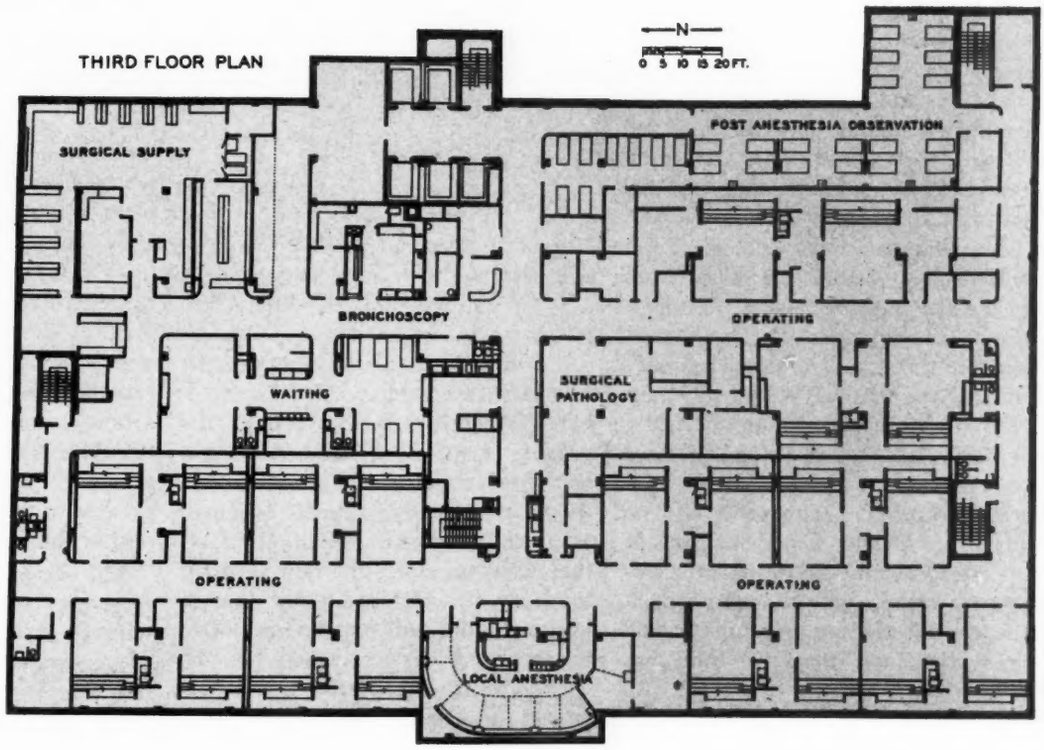

**These plans of a typical floor and one bed room illustrate the layout that will be general throughout the unit. Each floor will accommodate 62 beds in units of one, two and four bed rooms.**



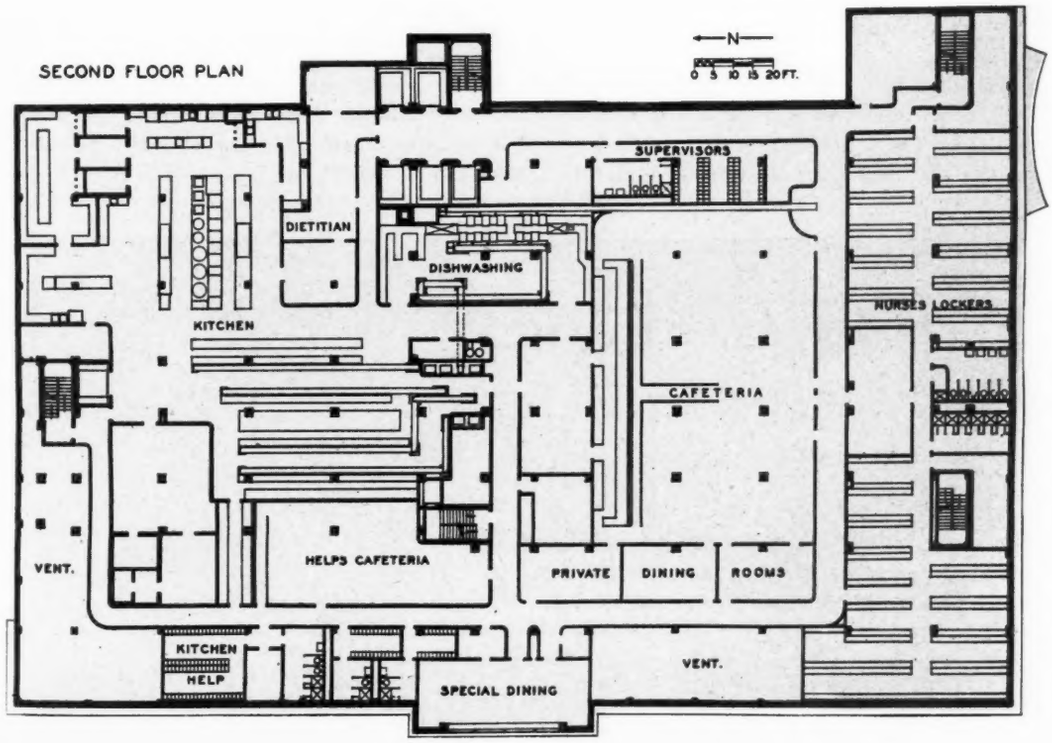

Above: Admitting and emergency departments will occupy a large section of the first floor. On this floor also will be located the receiving room and space for storing kitchen supplies.

Below: Plan of the basement of the first unit of the future Kahler Hospital. Here will be housed the central supply service from which all supplies and materials will be sent up to the floors on dumb-waiters. The housekeeping department, physical medicine department, storage rooms, drug store, barber and beauty shops will also be located in the basement.






Below: The second floor is to be turned over to food service, including kitchen, two cafeterias and private dining rooms. The dietitian's office is so located that she will command a view of the kitchen and dishwashing area. On this floor also space will be reserved for nurses' lockers. Above: Sixteen surgeries of similar size, four larger operating rooms and adjunct facilities, including anesthesia and post-anesthesia rooms are on the third floor. Waiting rooms are also provided.



while completing their schedule. While the surgeon is completing his work in one room the other room is prepared and general anesthesia is conducted in the operating room. With a few exceptions, the anesthesia rooms will be used entirely for spinal and local anesthesia.

In the post-anesthesia observation and recovery rooms the patients are in the care of nurses under the supervision of the anesthesia department and are to remain in this ward only during the critical period of their recovery from general anesthesia.

Sterilization of dressings, utensils and gloves can be done in the central workroom. Instruments will be sterilized locally for each pair of operating rooms. Water for the operating rooms will be sterilized in the central sterilizing room on the floor above and piped to each operating room.

On the surgical floor are waiting rooms for both in-patients and out-patients. There are also recovery rooms for in-patients and out-patients. Included in the latter group are the patients on the bronchoscopy service, which has a separate group of rooms located off of the main surgical corridors.

The hospital is located almost immediately adjacent to the clinic and, therefore, certain laboratory tests are completed in the clinic. The hospital has provisions for routine blood and urine examinations, radiographic rooms and cystoscopic examination rooms. These laboratories are located on the fourth floor immediately above surgery. Research laboratories are provided as part of the clinic buildings and are not incorporated in the hospital except that a research

laboratory depot will be provided adjacent to the routine laboratories.

Specimens for research will be collected in this space and transported to the main research laboratories, or certain problems may be completed here. When research problems requiring proximity to the bedside are being investigated, one of the bedrooms will be temporarily assigned as a laboratory for the duration of the problem. On the typical floor the bedroom adjacent to the housekeeping room will be provided with the necessary service outlets for the various utilities required in such a laboratory. The room will be temporarily outfitted for this purpose.

The administration department is located on the first floor. The medical admission for the majority of patients is completed as part of the medical examination in the clinic. This provision, of course, eliminates the necessity of a large admission department inasmuch as only the room assignments are made in the hospital. Adjacent to the ambulance entrance, emergency rooms are provided. This area also provides space for examining rooms for ambulance admissions. In relation to the size of the hospital the emergency service is extremely light since the population of the community is only approximately 30,000.

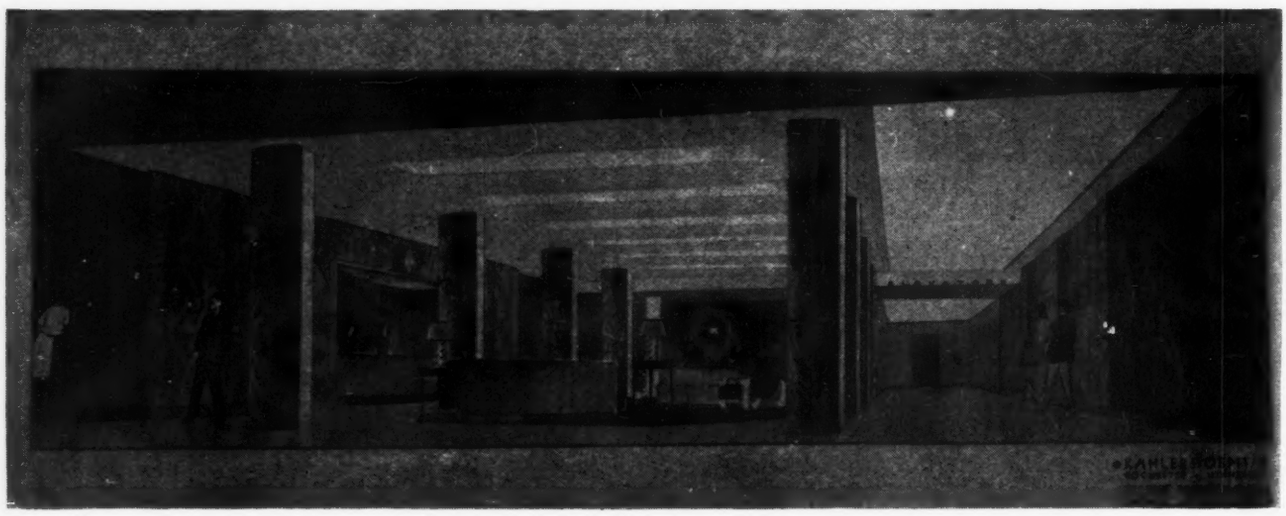
Charges for miscellaneous services and dressings frequently accumulate and sometimes fail to be entered on the patient's account before his dismissal. In order to eliminate this difficulty, a system similar to that used in hotels will be installed and the charge slips will be delivered to the cashier by conveyor or pneumatic tube.

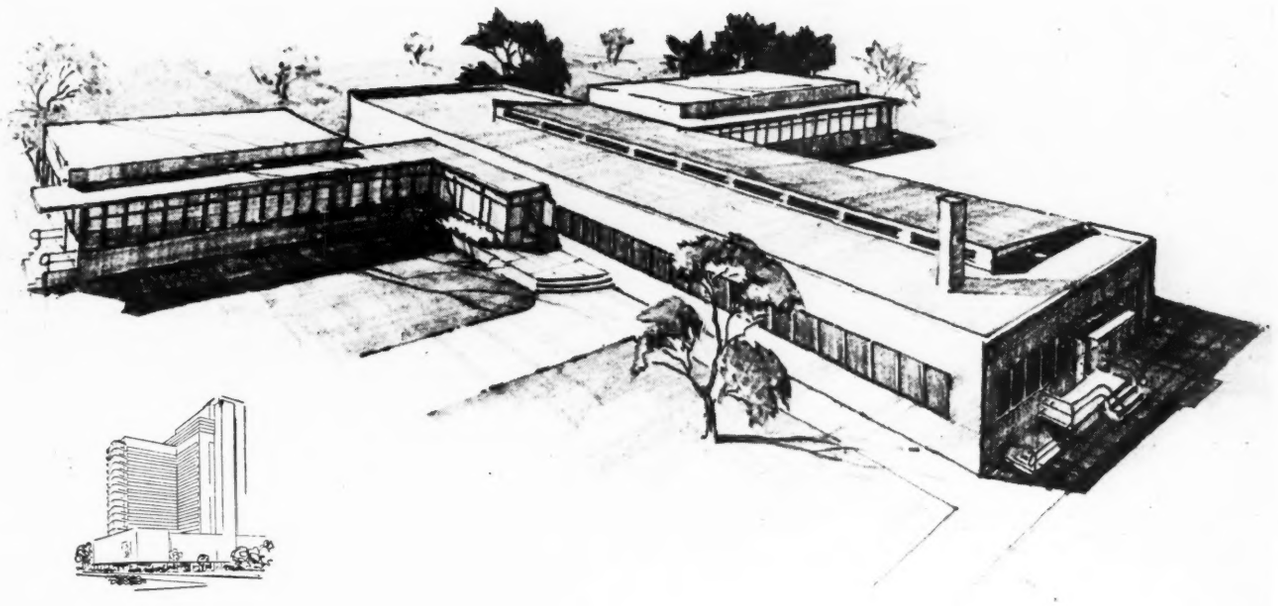
The Kahler Corporation has a central purchasing department that functions for its other institutions, as well as for the hospital. Likewise, several other administrative functions normally provided for in a hospital are cared for through the central offices of the Kahler Corporation. Thus, it is unnecessary to provide space for these functions within this building.

The supplies are received at the receiving room, which is provided with an enclosed loading dock. The storage rooms are divided into current supplies and bulk stock. The bulk stockrooms are in the sub-basement. The freight elevator in the receiving room serves the stockrooms, the kitchen and the operating rooms.

The Kahler Corporation has a central laundry serving all its institutions. The hospital laundry will be handled by truck through the receiving room and delivered to the housekeeping section in the basement. At this point it will be sorted, inspected and repaired. The floor maids, janitors and other housekeeping personnel will be under the supervision of the administrative housekeeper.

The four lower floors and the basement will be completely ventilated and certain portions will be cooled. The bedrooms will be air conditioned.





# HEALTH CENTER

# *Designed for* RURAL *Needs*

**J. R. McGIBONY, M.D.**

Senior Surgeon
Hospital Facilities Section
States Relations Division
U. S. Public Health Service

A BASIC weakness in the health and welfare structure of the nation is reflected in the need for improved health in rural areas. A markedly increasing number of rural communities, awakening to the need for improved health conditions, are seeking information to guide them in solving their local problems. The goal of many of these groups is a health center combining public health and clinical facilities and, in some instances, limited in-patient services.

However, the construction and operation of hospitals of fewer than 30 to 50 beds has long been controversial despite the fact that about 50 per cent of the general hospitals have fewer than this number. Admittedly, they are disproportionately expensive both to build and to maintain since they come within the range of rapidly diminishing returns from the standpoints of efficiency, economy and adequacy of care given.

Thus, under ordinary circumstances one would hesitate to recommend that a community embark upon such an expensive and possibly unsatisfactory venture. Examination of costs causes one to pause and reflect not whether the community needs such services but whether it can afford them. Every alternative, therefore, should be fully explored, including contracts with existing hospitals even if at a considerable distance. Such a contract, with local investment in full-time ambulance service, would probably be far cheaper in dollars. The larger hospital would have to be used anyway for most surgery and other complicated cases.

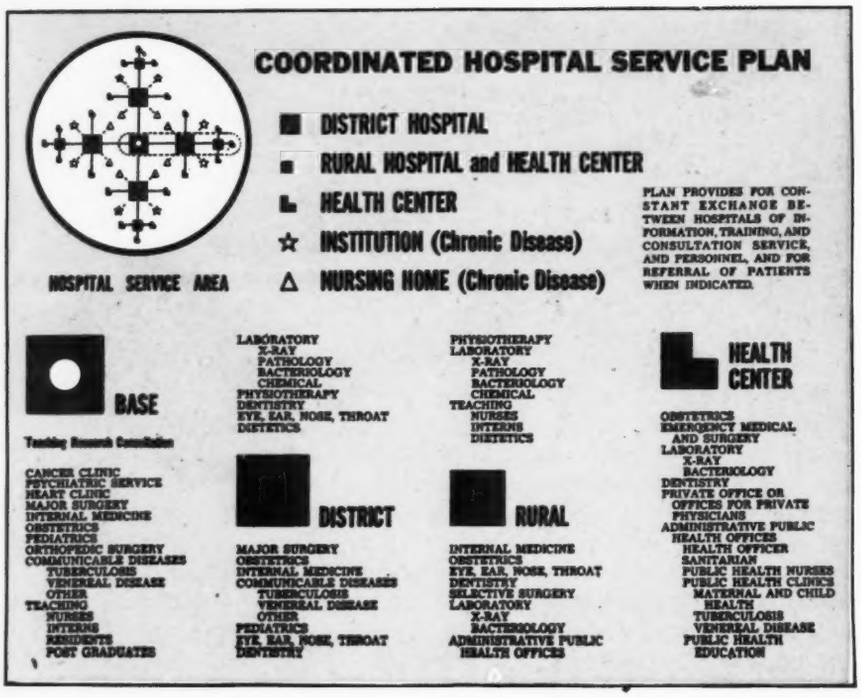
Despite the higher costs involved in the construction and operation of small hospitals, many communities desire such institutions because of pride as well as local necessity. They point out, correctly, that local facilities are essential to serve their health needs and that lack of such facilities is a major factor in discouraging physicians from remaining in rural communities. Family physicians are not inclined to transfer average cases to hospitals even 15 or 20 miles distant, where they can be in daily attendance; nor is such an arrangement satisfactory to patients and their families.

Since it is certain that large sums of public and private funds will be expended within the coming months for the construction of small institutions, and often without competent technical advice, the following material has been prepared as an aid in obtaining reasonable value for the money invested.

### Coordinated Program

An important initial step in formulating a hospital program for any community is to obtain all possible information on the subject from the state health department and other agencies concerned with hospitals and health facilities. This is of particular importance when a small facility is contemplated which will benefit by collaboration with the local public health program. Most states have under way, or are considering, surveys of all such facilities to determine additional needs. Any community plan will benefit by coordination with the total state program.

Operation of the local institution should contemplate affiliation with neighboring hospitals and medical centers. Quality of services rendered can be materially raised by use of available consultants, equipment and




adjunct clinical facilities. Administrative guidance and advice from the larger, better staffed institution will result in economy, efficiency and other benefits to the small hospital, to its patients and consequently to the community. Only by some such arrangement can fully adequate care be assured where limited facilities, staff, personnel and equipment are available.

### Estimates of Needed Beds

To estimate the number of beds required to serve a community adequately on a reasonable standard usually necessitates a compromise between a theoretical ideal and practical achievement.

On an ideal basis one must assume that a sufficient number of beds is the number necessary to accommodate all persons (other than tuberculosis and mental disease cases) requiring general hospitalization. One must assume, too, that all factors tending to limit hospitalization, such as distance, inability to pay for service and unwillingness to enter hospitals, will be removed or reduced to a minimum. From 75 to 80 per cent of beds occupied should be considered a normal daily average.

With these assumptions, the figure of 4.5 beds per thousand population has been determined necessary to meet the total needs. However, it is neither necessary nor desirable to establish beds in every community in exactly this ratio for several reasons.

In rural areas, with which this discussion is primarily concerned, it is believed that 2.5 beds per thousand population should be sufficient for the average community. Primary and secondary medical centers in which are concentrated specialized skills and facilities will serve patients referred from outlying areas as well as from their immediate areas. The ratio of beds then naturally becomes higher for the resident population of a given urban area.

This is the rationale for a difference in rural and urban bed ratios. It does not mean a different requirement for rural and urban people but an adjustment of bed concentration in accordance with ability to render a comprehensive service.

Population should be figured for the normal retail trade area, which is usually a radius of from 10 to 25 miles, depending somewhat on the density of population.

In initial construction, it is far better to provide a minimum of beds, attached to a health center, with provisions for future expansion as the factors limiting hospitalization are overcome. Thus, in a rural area which has never had a hospital, considerably less than the bed ratio given might well constitute the initial investment. Hospital operation is expensive and the community should not be burdened with more than can be supported efficiently.

The small number of beds in the typical rural health center and hospital will tend to make the community health and hospital conscious by concentrating on that phase of inpatient care which it is probably best fitted to render, that is, normal obstetrics. In 1943 the general average of hospital births for rural areas was 51.2 per cent, dropping to less than 25 per cent in some areas. In contrast, urban areas revealed 86.9 per cent hospital births. Thus, great expansion of service is possible.

While it is true that a good home delivery is better than one in a poor hospital, far too many rural homes cannot provide adequate facilities for confinement and maternal and infant care. With proper management a much larger proportion of the approximately 20 babies born to each thousand population in rural areas can receive proper obstetrical care. This would reduce the number of babies who are born alive but who die within the first year, more than 40 of each thousand live births.

At the same time much suffering would be saved the mothers, of whom more than 2.5 out of each thousand die as a result of complications of pregnancy each year.

Hospital care for general disease conditions would, of course, be furnished to the limit of adequacy of facilities. This would vary with type of service needed, the physical plant, funds available for annual operation, nearness of other facilities and, of major import, the quantity and quality of medical personnel available.

### Aid in Diagnosis

Study by a competent hospital consultant would aid in determining the need, including that for maternity care as previously discussed, by analyzing sickness, accident and death rates in the community. Records of actual sickness rates are not usually available, as the vast majority of illnesses cause only temporary disablement, are not communicable and hence are not reported. While in the average community, the majority of patients are successfully treated in the home, hospitalization, even in a very small health center, would often make the patient more comfortable, aid in earlier and better diagnosis, help prevent complications and promote early recovery. At the same time spread of certain diseases to others would be better controlled.

Few communities requiring an institution of this size will have suf-

ficient major surgical cases to permit limitation of practice to that specialty. Approved hospitals are attempting to limit performance of surgery to members of their staffs who not only have adequate experience and training but limit their practice to this field. This is not a reflection upon the family physician, the "general practitioner," for, although he is not a surgeon, he is, in truth, a specialist of the first order. No one can maintain proficiency in every phase of medicine and surgery.

The attitude and ability of the local medical profession will determine, in large measure, the type and quality of care given and, because of this, will spell the success or failure of the health program. Both the practitioner and his patients must realize human limitations and the impossibility of duplicating research medical center care in an institution and under circumstances designed for local rural use.

Thus, obstetrical and general medical services would form the larger part of the bed care given in the small rural health center.

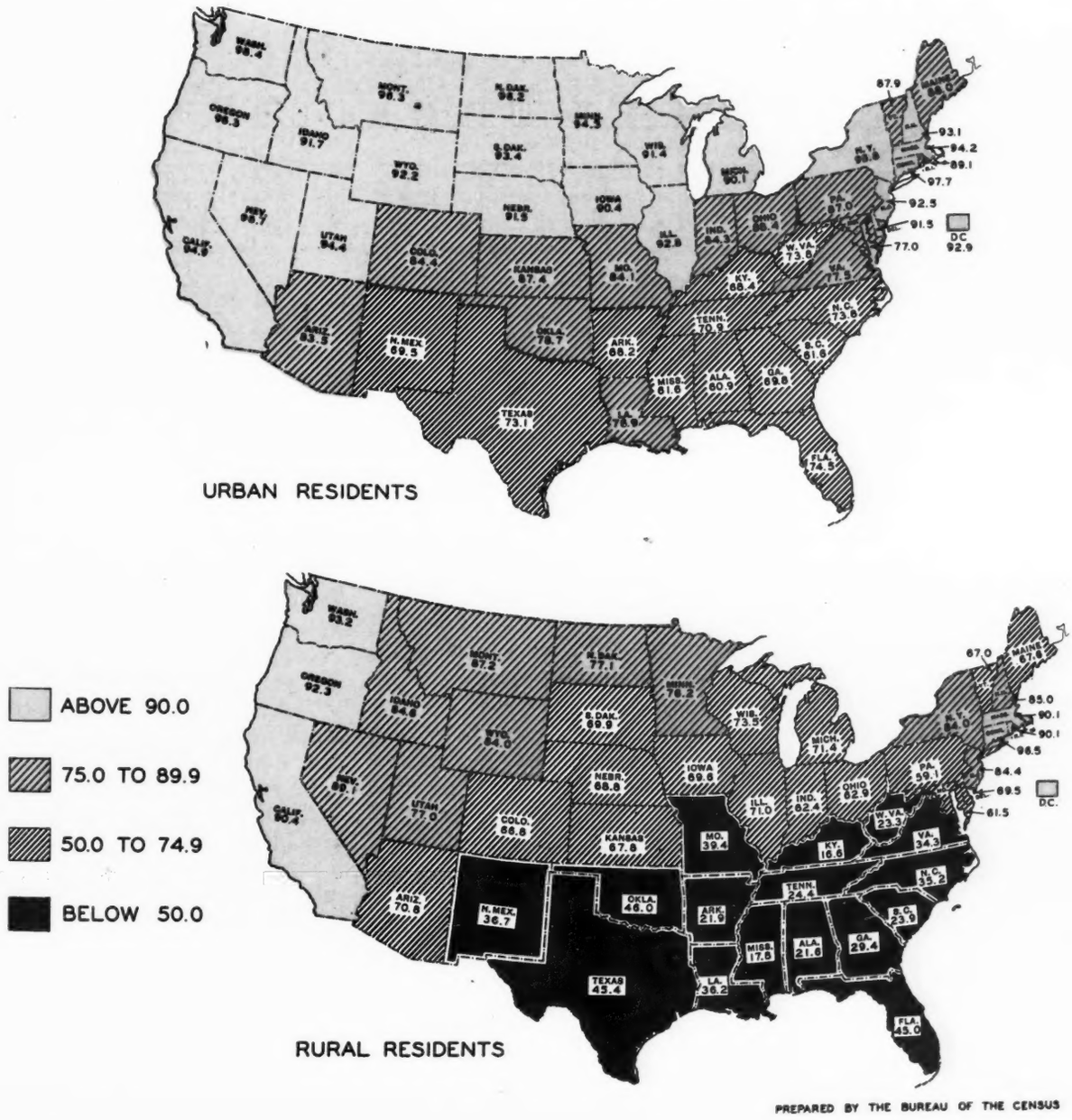
### Site Selection

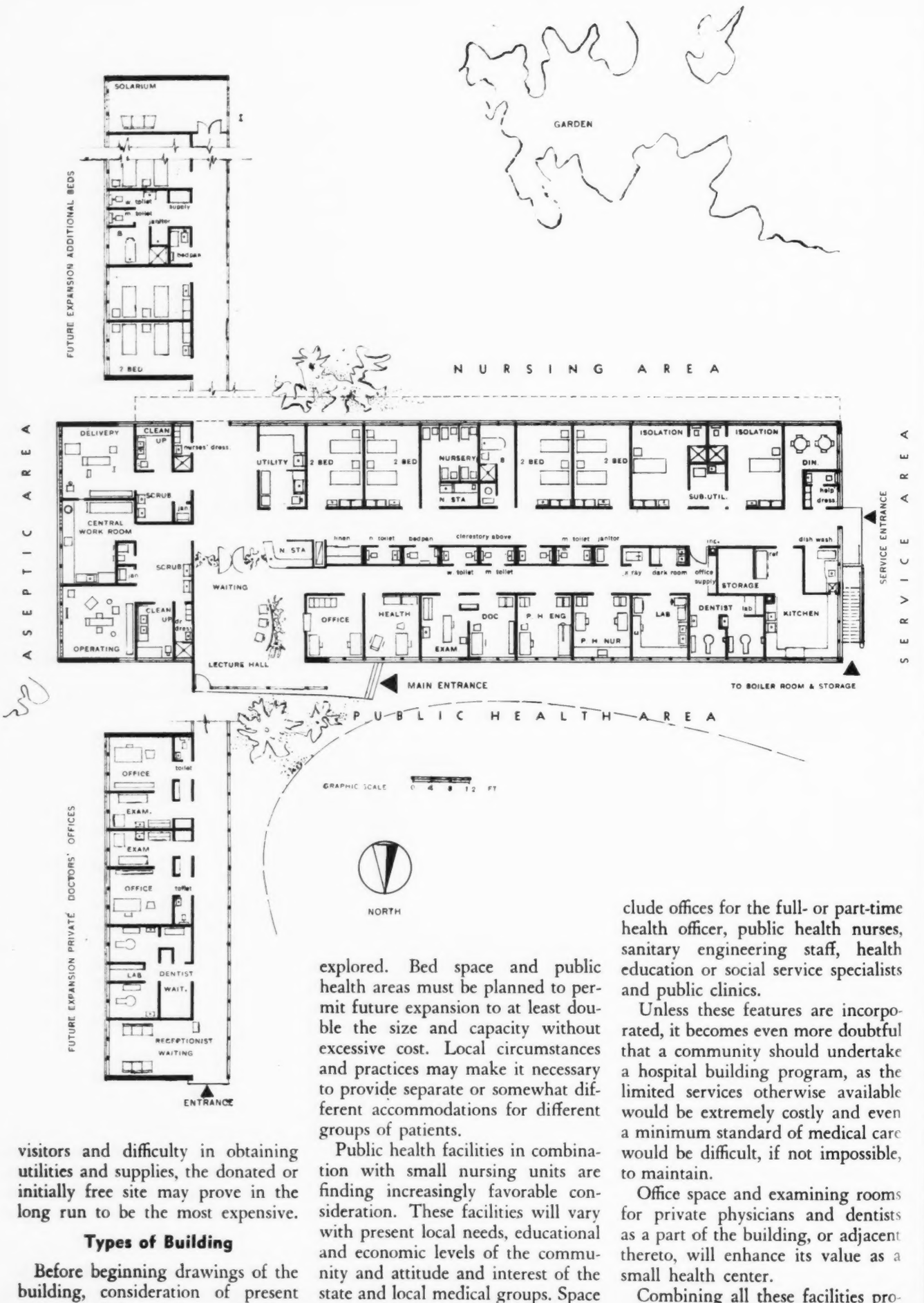
A hospital site should be selected because of one factor, suitability for present use and for future expansion. The minimum size should permit at least doubling the original building without crowding or encroachment.

Generally speaking, the small rural health center is better patronized and can discharge its community obligations more efficiently if it is located as near as possible to the center of the town or village. This is particularly true if public clinics and private physicians' and dentists' offices are combined with bed facilities. Traffic and other objections present in the cities are not often of great import in the smaller community.

Locations for hospitals and health centers are often selected because of availability as a gift or because of local governmental ownership rather than for adequacy or acceptability for the purpose. Thus, because of inconvenience to patients, staff and

FIGURE 2.—PROPORTION OF BIRTHS IN HOSPITALS, URBAN AND RURAL: EACH STATE, 1943






visitors and difficulty in obtaining utilities and supplies, the donated or initially free site may prove in the long run to be the most expensive.

### Types of Building

Before beginning drawings of the building, consideration of present and expanded services must be fully explored. Bed space and public health areas must be planned to permit future expansion to at least double the size and capacity without excessive cost. Local circumstances and practices may make it necessary to provide separate or somewhat different accommodations for different groups of patients.

Public health facilities in combination with small nursing units are finding increasingly favorable consideration. These facilities will vary with present local needs, educational and economic levels of the community and attitude and interest of the state and local medical groups. Space for such activities will usually include offices for the full- or part-time health officer, public health nurses, sanitary engineering staff, health education or social service specialists and public clinics.

Unless these features are incorporated, it becomes even more doubtful that a community should undertake a hospital building program, as the limited services otherwise available would be extremely costly and even a minimum standard of medical care would be difficult, if not impossible, to maintain.

Office space and examining rooms for private physicians and dentists as a part of the building, or adjacent thereto, will enhance its value as a small health center.

Combining all these facilities promotes continuity of health and med-

ical services, provides convenience to patients and staff and serves economy through unified administration and use of common adjunct services, such as x-ray and laboratory. Such combination is almost essential for success of the small institution if it is to be responsible for really adequate care upon a sound economic basis.

For hospital purposes alone approximately 575 square feet per bed is necessary to provide bed space and all adjunct services. Bedrooms are designed preferably for two, but never more than four, beds in a small facility, each bed requiring at least 80 square feet in the room. Thus, the 10 bed health center and hospital will require 5500 to 6000 square feet of floor space just for the hospital features. Construction should be on one floor and as nearly fireproof as possible.

Additional space required for public health activities will, of course, vary, but not less than 2000 square feet will probably be necessary.

For private physicians' and dentists' offices and examining rooms, a minimum of 300 square feet for each may suffice, exclusive of waiting rooms which may be joint or separate.

The accompanying plan has been designed by the architectural unit of the Hospital Facilities Section. It embodies most of the basic needs of the small but fairly complete health center-hospital and yet is flexible enough to permit the local architect to adapt it to specific community requirements.

Nursing and administrative supervision is maintained from a central point. Immediate in-patient areas receive desirable exposure. A compact unit for emergency surgery and obstetrics is shown with adequate separation; it has only a pass window for sterile supplies opening between the work and delivery rooms. Some hospitals still use the operating room for delivery but the practice is not approved by some authorities, even in small hospitals. Limited driveways provide for both service and main entrance.

If initial construction is minimum, future expansion is possible on any axis of circulation. This arrangement also permits separate nursing units for different categories of patients by simple duplication of the nursing unit illustrated.

Private office space, of course, may not be necessary or desirable in some instances. For this reason that area is not shown in complete detail and may be omitted without affecting the basic plan.

In those unusual communities in which satisfactory facilities are already available for public health activities some readjustment in the area shown will be indicated. Modular design will permit the competent local architect to accomplish this without major dislocation of basic pivotal hospital units shown.

### Remodeling Existing Buildings

A common impression of the public is that a hospital is simply a house or building with beds, which is far from the truth. A hospital, however small, is a complicated institution, designed as a tool for the physician, and to a marked degree its efficiency in planning, organization and management affects the efficiency of his services to the patient.

An existing house or building, not designed as a hospital, usually proves to be the most expensive of ventures when converted to such use. Upkeep is higher, efficiency, safety and sanitation are usually much more difficult, remodeling is constant, expensive and never satisfactory.

### Construction Costs

Assuming, for practical purposes, that the average small community will need, initially, for 10 beds and other services, approximately 8000 feet of floor area, the matter of construction cost arises. Exact figures cannot be specified, of course, because of differences in labor and material costs in various sections of the country. Such figures can be supplied by an architect who is familiar with local conditions. The architect should be included on the planning committee from the beginning and preferably should have had experience in hospital building.

To the local costs of ordinary house or building construction must be added approximately 20 per cent to cover the unusual expensive methods, material and equipment required for hospitals. Thus, costs of hospital construction will vary from $5 to $10 per square foot, which may be roughly divided into 50 per cent for labor and 50 per cent for material and equipment.

Equipment, including x-ray, sterilizers, beds, desks and other necessary items, will amount to from $500 to $800 per bed, or approximately $1 per square foot of floor area.

Supplies, to begin operating, amount to about $200 per bed.

### Operating Costs

Only hospital services will be considered here, as public health activities will vary with funds appropriated for the purpose, with the interest and ability of the director and staff and with the amount of interest it is possible to stimulate in the people of the community by health education measures.

The major expenditures for the average small hospital are for personnel, food and other supplies, all of which are proportionately higher than for larger institutions. Expenses of operation based on experience may be roughly divided as follows in hospitals throughout the country:

| | |
|---|---|
| Salaries and wages | 50% |
| Supplies and equipment | 20% |
| Foodstuffs | 15% |
| Heat, light, power | 5% |
| Repairs and replacement | 5% |
| Insurance and miscellaneous | 5% |

### Personnel

The smaller the institution the higher will be the proportion of salaries because there is a limit to patient-personnel ratio in rendering even minimum adequate care.

For comparative purposes, the general hospitals in the United States, in 1944, averaged 60 employes for each 100 beds in institutions up to 25 beds. (*Hosps.* **19**:37 [August] 1945.) Larger proportions are required in the smaller units and the number recommended by hospital administrators is 1.5 employes for each patient. It is not feasible for the poorer communities to begin with the latter ratio, but an absolute minimum for the 10 bed health center and hospital might be considered as one employe per bed. Additional services would have to be contributed through clubs or other organizations and by private nurses.

While rearrangement of positions, duties and salaries would be caused by local conditions (including assumption of part-time hospital work by members of the public health staff, particularly the director and technician), the following minimum, with average annual salaries, exclu-

sive of contributed services, is suggested:

| | |
|---|---|
| 1 Director-Chief Nurse | $ 3000 |
| 2 Staff Nurses @ $1800 | 3600 |
| 1 Clerk-Stenographer | 1500 |
| 1 Technician | 1800 |
| 2 Attendants | 1200 |
| 1 Cook | 1500 |
| 1 Assistant Cook | 1200 |
| 1 Laborer | 1200 |
| Total Personnel | $15000 |

### Annual Supplies and Equipment

It has been estimated that from $100 to $200 per bed is necessary for supplies on hand to permit a hospital to begin operating. In 1944 annual costs of supplies in 1300 hospitals under 25 beds averaged $455 per bed, which would mean from $4500 to $5000 per year for the 10 bed health center and hospital under discussion. Food constitutes about half of this cost, the remainder being for linens, dishes, cleaning and household supplies, fuel and miscellaneous items. Annual equipment purchases of hospitals of this size showed an average cost of $78 per bed in the United States in 1944.

Light, power, maintenance and repairs would approximate $100 per bed, a total of $1000 for the 10 bed unit.

Insurance, legal and miscellaneous expenditures should not exceed $1000.

Laundry costs, part of which might be absorbed in some of the charges listed, would be an important fixed cost. It has been found uneconomical, generally, for a hospital under 50 beds to operate its own laundry, so the letting of such work to a commercial laundry, if one is available, while it would require a larger linen stock, would be the best solution. Hospitals will average 12 pounds of laundry per patient each day. Assuming the 10 bed unit to average seven patients daily, this would mean 30,000 pounds of laundry annually. At an average commercial rate of 5 cents per pound, this totals $1500.

Estimates then, for operating the 10 bed unit, would cost the community as follows:

| | |
|---|---|
| Salaries and wages | $15,000 |
| Supplies | 4,700 |
| Equipment | 800 |
| Laundry | 1,500 |
| Light, power, repairs | 1,000 |
| Insurance, miscellaneous | 1,000 |
| Total annual cost | $24,000 |

Based on an annual cost of $2400 per bed, the daily cost would be $6.57. However, no hospital can expect 100 per cent occupancy, so, on the theory that there would be a daily average of seven patients for the 10 beds, the cost per patient would be $9.40 each day, and this with a minimum staff.

That these theoretical figures can be reduced in actual practice is shown in an analysis of 113 hospitals in Kansas as reported by Beelman and Steinmeyer in the *Kansas Government Journal,* July 1945. This analysis revealed that hospitals of from 1 to 25 beds numbered 52, or 46 per cent of all hospitals studied. They had 644, or 11.6 per cent, of the total beds, for an average size of 12 beds. These beds were only 50 per cent occupied, rendering 8.2 per cent of all in-patient care.

Costs in this group of small hospitals averaged $4.99 per day per patient. While they might be considered as an average sample for the country, the wide variation in cost accounting, the type, variety and quality of service, salary scales and price level of supplies was so apparent that specific application of their average experience to any other particular community might be questionable. Too, the volunteer services and shortages among physicians, nurses and even untrained personnel during the war year 1944, the period covered by the report, make difficult the projection of findings into the postwar years.

However, it can be seen that hospitals are expensive institutions and the smaller they are the more expensive per patient. It may be difficult for the average community requiring only this small unit to operate it successfully without outside aid or by some assured method of prepayment.

The first consideration, then, might be the affiliation with a hospital insurance plan, such as the Blue Cross plan, or comparable cooperative. At the present time approximately 20,000,000 people in the United States prepay hospital bills through the Blue Cross method, while at least 10,000,000 more benefit from commercial and industrial plans. About one of every eight members receives hospitalization during a year, for an average stay of eight days. Costs vary with services rendered but average about $2 a month per family.

In the community under consideration a portion of funds so collected would have to be used to defray expenses of patients referred to larger hospitals for special services, since the 10 bed facility could not be sufficiently equipped and staffed for complete diagnosis and treatment of all conditions.

Regardless of these collections, however, the local government or other agencies would probably have to assume a substantial portion of the financial burden. A considerable portion of patients in the average community hospital are "free" cases. Some responsibility would have to be assumed if those in greatest need are to receive care. The hospital should not function on such a deficit basis, curtailing standards of care in order to survive, but should be paid for the high quality of service given even though it is limited in scope.

### Poor Hospital a Danger

If such a program is feasible for the community, improved health will contribute to improved economics, so that the problem should become progressively easier. The decision, made today, must be projected into the future, a future perhaps of uncertain economic and social conditions. A poor hospital is a danger to the community, and a venture as expensive as a good hospital should not be undertaken without the founders being able to foresee events sufficiently to avoid an embarrassing financial burden.

From the standpoint of cost, however, the question may be not that the community cannot afford it but, measured in lives and suffering, that it cannot afford to be without it.

For communities planning health centers and hospitals, the Hospital Facilities Section of the U. S. Public Health Service has available plans and suggestions for various types and sizes of institutions. Also, the American Hospital Association has, among other valuable material, an excellent brochure entitled, "Measuring Your Community for a Hospital."

## NEW WING

# FUNCTION
## *Dictates Modern Layout*

**CARL A. ERIKSON**
Schmidt, Garden and Erikson
Architects and Engineers
Chicago

ALL over the country, hospitals of all sizes and types are planning to respond to the heavy pressure on their existing space and facilities by building additions at the earliest possible moment. In many cases construction is already under way. Those that are still in the planning stage will do well to review the whole building project to make certain that full advantage is being taken of the opportunity to modernize functionally as well as to add space.

The expansion and remodeling of a hospital built more than forty years ago, for example, can usually accomplish more than simply providing beds for a larger number of patients and enlarging service facilities accordingly. It should also do as much as possible toward bringing functional design in line with scientific medicine as it is practiced today, with all its new procedures and methods that were not even in existence at the time the hospital was built.

The remodeling of Hackley Hospital at Muskegon, Mich., presented here, accomplishes all these objectives. Hackley Hospital was built in 1904 with funds provided by Charles H. Hackley, millionaire Michigan lumberman whose philanthropy also built and endowed many of Muskegon's public institutions and recreation facilities. The Hackley Hospital grounds, covering four square blocks in the middle of the city, are famous throughout the state for their beautiful lawns and gardens.

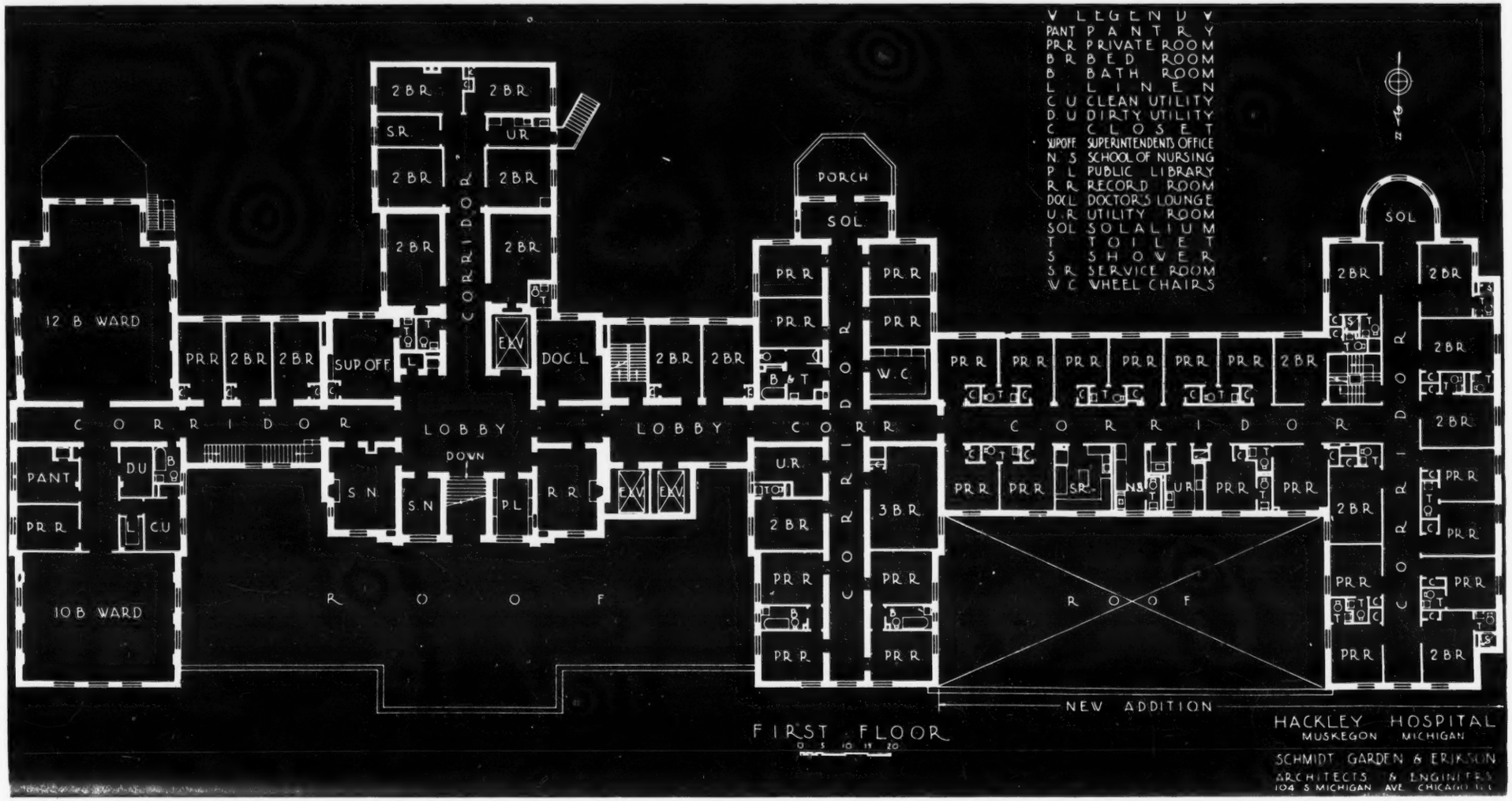
Originally built for 50 beds, the hospital had already been enlarged somewhat at the time it was described in an article in The MODERN HOSPITAL for October 1918. During the remodeling discussed here, the bed capacity of the hospital was increased from 104 to 184, and corresponding expansion of other facilities was achieved at the same time. Bob D. Dann is administrator of the enlarged Hackley Hospital today.

In addition to the necessary expansion, important functional improvements were undertaken at the time the latest addition was built. One of the big advances in medicine over the last thirty years, for example, has been the development of precise diagnostic methods requiring the use of extensive scientific equipment. The x-ray departments and clinical and pathological laboratories are, of course, the outstanding examples.

As use of these and other facilities consistently increases, they become more and more needed for out-patients as well as for bed patients in the hospital today. Thus, the arrangement of space should, if possible, make such facilities conveniently available alike to out-patients and to attending physicians in the hospital.

Moreover, the physician's time will be conserved if all these facilities occupy space in the same part of the building; this will make it unnecessary for the doctor to go from floor to floor and from corner to corner of the building to consult with radiologists, pathologists, technicians and others and to review all the records accumulated during the care of a single patient. Similarly, the patient or out-patient for whom a complete diagnostic work-up is being made may use these facilities more conveniently if they are located in one place.

The ground floor plan of the remodeled Hackley Hospital shows


LEGEND
PANT PANTRY
PR.R PRIVATE ROOM
B R BED ROOM
B BATH ROOM
L LINEN
C U CLEAN UTILITY
D.U DIRTY UTILITY
C CLOSET
SUPOFF SUPERINTENDENTS OFFICE
N. S SCHOOL OF NURSING
P L PUBLIC LIBRARY
R R RECORD ROOM
DOC.L DOCTOR'S LOUNGE
U.R UTILITY ROOM
SOL SOLALIUM
T TOILET
S SHOWER
S.R SERVICE ROOM
W.C WHEEL CHAIRS
12 B WARD
10 B WARD
2 B R
S.R
U.R
PORCH
SOL
PR.R
SUPOFF
DOC.L
W.C
B & T
CORRIDOR
LOBBY
PANT
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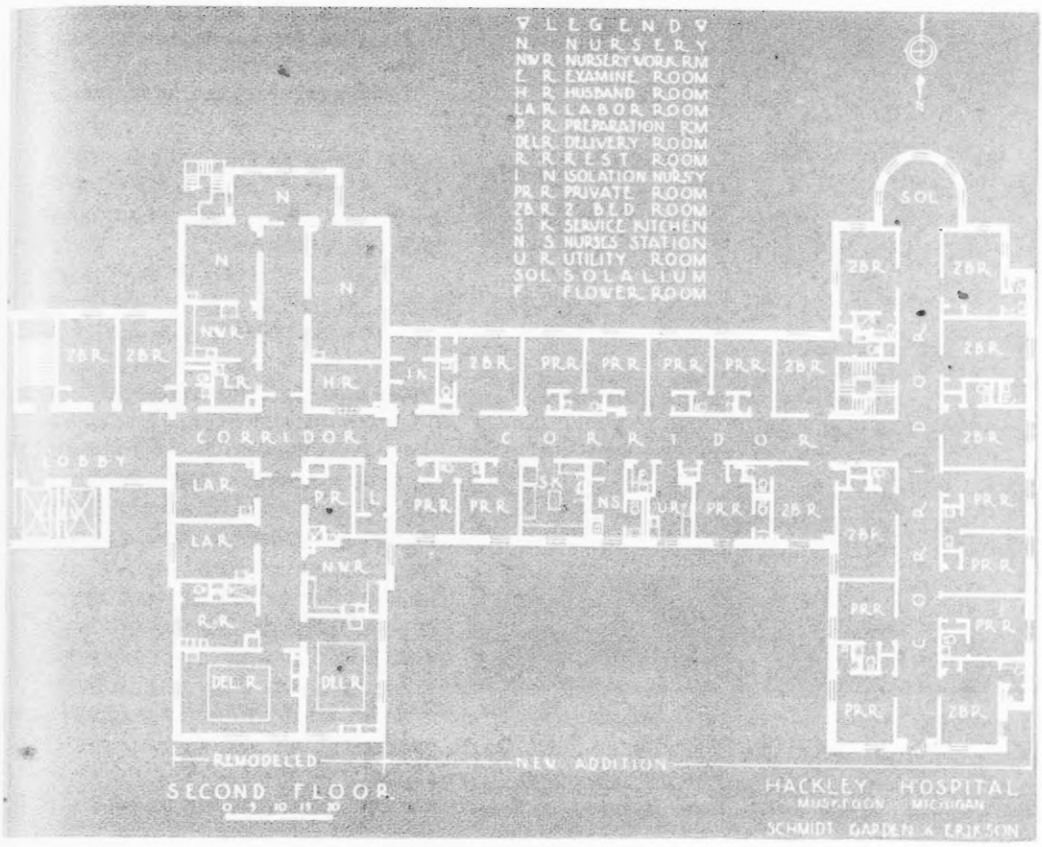
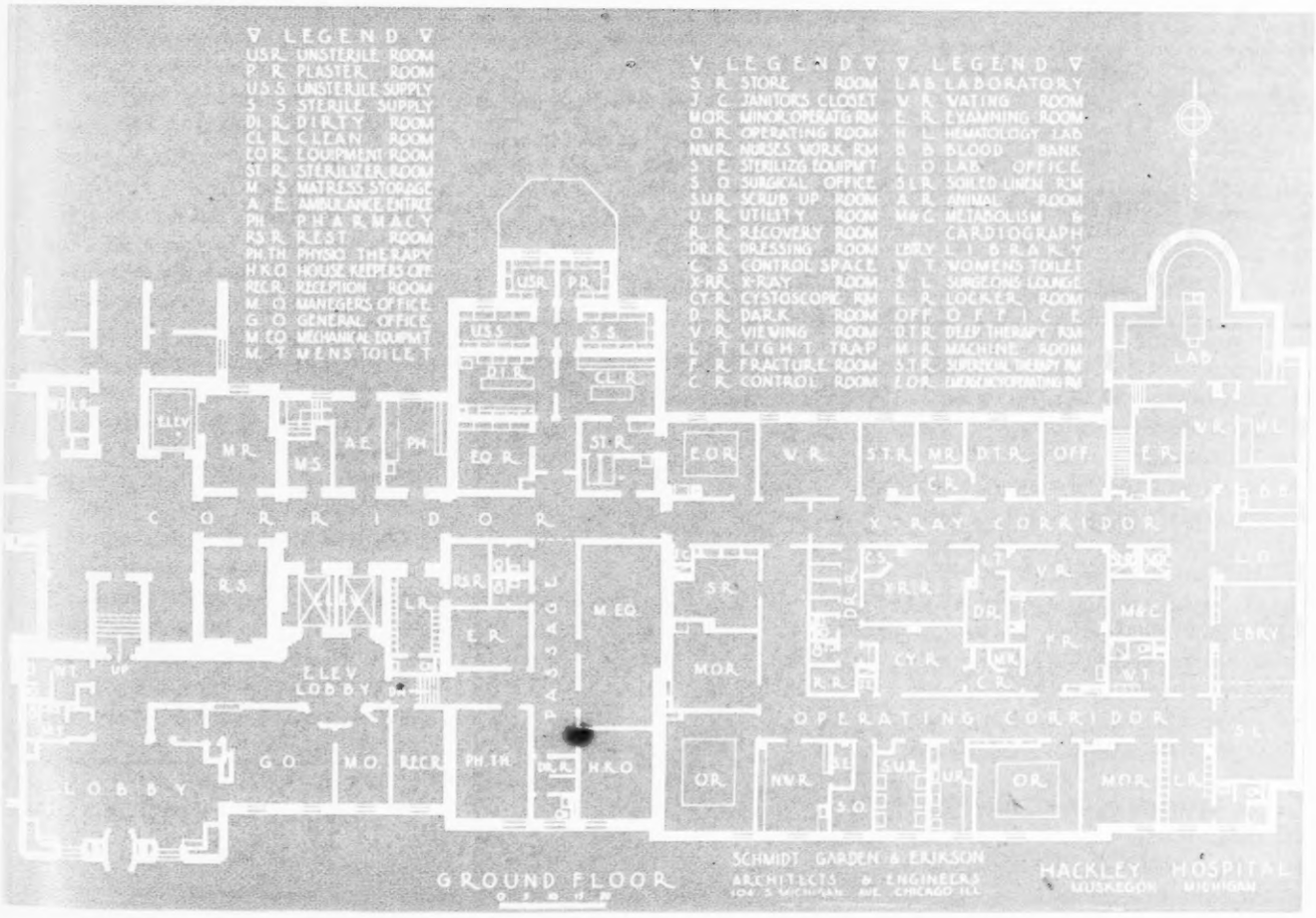
3 B R
R O O F
NEW ADDITION
FIRST FLOOR
0 5 10 15 20
HACKLEY HOSPITAL
MUSKEGON MICHIGAN
SCHMIDT GARDEN & ERIKSON
ARCHITECTS & ENGINEERS
104 S MICHIGAN AVE CHICAGO ILL


LEGEND
N NURSERY
NWR NURSERY WORK RM
E R EXAMINE ROOM
H R HUSBAND ROOM
LA R LABOR ROOM
P R PREPARATION RM
DEL R DELIVERY ROOM
R R REST ROOM
I N ISOLATION NURSY
PR R PRIVATE ROOM
2BR 2 BED ROOM
S K SERVICE KITCHEN
N S NURSES STATION
U R UTILITY ROOM
SOL SOLALIUM
F FLOWER ROOM
CORRIDOR
LOBBY
REMODELLED
NEW ADDITION
SECOND FLOOR
HACKLEY HOSPITAL
MUSKEGON MICHIGAN
SCHMIDT GARDEN & ERIKSON


LEGEND
US R UNSTERILE ROOM
P R PLASTER ROOM
US S UNSTERILE SUPPLY
S S STERILE SUPPLY
DI R DIRTY ROOM
CL R CLEAN ROOM
EQ R EQUIPMENT ROOM
ST R STERILIZER ROOM
M S MATRESS STORAGE
A E AMBULANCE ENTRNCE
PH PHARMACY
RS R REST ROOM
PH TH PHYSIO THERAPY
H K O HOUSE KEEPERS OFF
REC R RECEPTION ROOM
M O MANEGERS OFFICE
G O GENERAL OFFICE
M CO MECHANICAL EQUIPMT
M T MENS TOILET
LEGEND
S R STORE ROOM
J C JANITORS CLOSET
MOR MINOR OPERATG RM
O R OPERATING ROOM
NWR NURSES WORK RM
S E STERILIZG EQUIPMT
S O SURGICAL OFFICE
SUR SCRUB UP ROOM
U R UTILITY ROOM
R R RECOVERY ROOM
DR R DRESSING ROOM
C S CONTROL SPACE
X-RR X-RAY ROOM
CY R CYSTOSCOPE RM
D R DARK ROOM
V R VIEWING ROOM
L T LIGHT TRAP
F R FRACTURE ROOM
C R CONTROL ROOM
LEGEND
LAB LABORATORY
V R VATING ROOM
E R EXAMINING ROOM
H L HEMATOLOGY LAB
B B BLOOD BANK
L O LAB OFFICE
S L R SOILED LINEN RM
A R ANIMAL ROOM
M&C METABOLISM & CARDIOGRAPH
LBRY LIBRARY
W T WOMENS TOILET
S L SURGEONS LOUNGE
L R LOCKER ROOM
OFF OFFICE
D T R DEEP THERAPY RM
M R MACHINE ROOM
S T R SUPERFICIAL THERAPY RM
E O R EMERGENCY OPERATING RM
CORRIDOR
X-RAY CORRIDOR
OPERATING CORRIDOR
LOBBY
ELEV LOBBY
GROUND FLOOR
SCHMIDT GARDEN & ERIKSON
ARCHITECTS & ENGINEERS
104 S MICHIGAN AVE CHICAGO ILL
HACKLEY HOSPITAL
MUSKEGON MICHIGAN

**Left: The new wing of Hackley Hospital, Muskegon, Mich. Below: Remodeled corridor in old building, showing cashier's office.**

## • OUTLINE OF CONSTRUCTION DETAILS

**CONSTRUCTION, FINISHES AND EQUIPMENT:** Construction, back-up tile, brick and stone exterior, fireproof throughout. Interior partitions, hard tile and gypsum block. All window sash, wood, double hung. Terrazzo stairs, plaster railing with art marble cap, wood handrail.

**FLOORING:** Terrazzo floor and base in lobby, toilets, birth and nursery departments, operating rooms, x-ray rooms, sterilizing rooms, scrub-up and work rooms. Asphalt tile floors and base in patients' rooms, corridors, elevator lobby, cafeteria, nurses' dining room and solarium.

**WALLS:** Glazed tile wainscot in operating rooms and nurses' workroom.

**CEILINGS:** Acoustical tile in corridors, lobby, offices, library, utility rooms, delivery rooms, labor rooms, nurses' workrooms, cafeteria and nurses' dining room.

**HEATING:** High-pressure boiler, low-pressure vacuum system for heating, high-pressure steam for sterilizers. Convector radiators.

**VENTILATION AND AIR CONDITIONING:** Operating rooms and birth and nursery departments, air conditioned by well water from central system. Toilets, utility rooms, service units, exhaust mechanical ventilation.

**LIGHTING:** Corridors on second and third floors, alternate fluorescent and germicidal fixtures. Nurseries, delivery rooms and examination rooms, fluorescent fixture and germicidal fixture at doors.

**CALL SYSTEM:** 12-volt nurses' call systems.

**ELEVATORS:** Automatic, self-leveling, center opening horizontal sliding door, 75 feet per minute. No dumb-waiter.

**X-RAY EQUIPMENT:** Complete diagnostic and therapy equipment.

**REFRIGERATION:** Separate units.

that many of these objectives have been accomplished. Diagnostic facilities are directly available to out-patients coming from both the emergency entrance and the main lobby; they are all located on the same floor, in the same part of the hospital; they are also convenient to physicians using the operating room facilities, an important feature because of the many emergencies in which doctors need to know the results of a laboratory or x-ray procedure while the patient is still in the operating room.

The cystoscopy room, used alike for diagnostic and surgical purposes, is so located that it is at once a part of the operating room suite and, by another entrance, conveniently available to out-patients.

While the advances in modern scientific medicine make many demands on the plan and design of the hospital, advancing technology at the same time permits design features which were not possible in earlier days. It used to be considered necessary, for example, to have the operating room suite of the hospital on the top floor, removed as far as possible from sources of noise and dirt and having the greatest advantage of natural lighting. This is no longer necessary.

Artificial lighting, soundproofing and air conditioning now make it possible for the operating room to be placed functionally. At Hackley, for example, the operating rooms are on the ground floor in the new part of the building. Complete sealing from outside dust, together with central ventilating and air-conditioning systems, makes this arrangement safe and desirable.

The same factors also make it possible for the x-ray room, fracture room and cystoscopy room to be located on inner corridors and for the laboratory, with all its delicate instruments, to have an outside, ground floor location.

An interesting feature of the Hackley plan develops from the fact that the ground on which the hospital is built slopes steadily from east to west (from left to right in the pictures and plans presented here). At the lower level of the slope, the ground floor is thicker than the rest of the building; this is clear from a comparison of the ground floor and first floor plans.

The lobby and business offices in the remodeled space in the old building are located on the first floor. The operating rooms, x-ray department, laboratory and other diagnostic and out-patient facilities are on the ground floor, in the new building.

***End of Portfolio on Hospital Design and Construction***

*— Honorable Mention Essay —*

# Ten Steps Toward Better Care *for psychiatric patients*

**GEORGE H. PRESTON, M.D.**
Commissioner of Mental Hygiene
Maryland State Board of Mental Hygiene, Baltimore

NO BUILDING ever cured a patient. Neither medicine, psychiatry, hydrotherapy, occupational therapy, dietetics, drugs, electricity, music, dramatics, surgery, psychoanalysis, religion nor psychiatric social work ever cured a patient. Recoveries occur only when such technics are applied directly and continuously to individual patients by trained people. People, not things or theories, cure patients.

Because people, not things or theories, cure patients a psychiatric hospital must provide *a controlled environment in which continuous and intimate contact can be maintained between psychiatrically trained people and psychiatrically ill patients so that all patients can, at all times, obtain the benefits of every known psychiatric skill.*

If this objective could be reached, immediate improvement in hospital care would result. If, from day to day, each new advance in treatment could be added to hospital practice, the problem of good care would be solved for succeeding tomorrows. How can this be done?

The answer includes some changes that will seem rank heresy to conventionally trained hospital men, some that will not go far enough to meet the views of persons who are not hospital trained and others that will disturb state finance officers.

Some hard, practical facts must be noted. We are talking about improving hospital treatment for psychiatric patients. That means improving care in state hospitals because the vast majority of hospitalized psychiatric patients are treated in state institutions. These hospitals represent a huge investment in buildings, in civil service employes, in retirement funds and in land and equipment. This investment will not be abandoned.

Improvement in hospital care, therefore, means improvement in state hospital care, within the existing framework. Nothing else is practical. When state hospital care improves, private hospitals must improve or starve. That answers their question.

Most state hospitals are large communities remote from active metropolitan centers. They must operate all the facilities of a small town. Sewage disposal may not sound like psychiatry but sewage disposal, water, laundry, heat, light, transportation, food, sewing on buttons, repairing shoes, delivering mail, controlling Bang's disease, running a fire department, a motion picture theater, a dance hall, three or more church services and preserving a strict moral code are all part of psychiatry in state hospitals.

How much clothing may a patient be allowed to destroy? How much noise may he make? What food must he have? How much hot water and what kind of hot water faucets? What floor polish or roach killer may be used? At which jobs, for what hours and where may a patient work? What colors are the walls to be painted? What bed springs should be bought? What about visiting days and hours? How about letters to and from patients? Should the patient go to church?

Try to answer these questions if you have not had psychiatric hospital experience. You will end up on a ward or in jail and your patients will not recover. Nothing, literally nothing, ever happens in a psychiatric hospital that does not have psychiatric implications. This fundamental fact must dominate all administrative organization. It must be the primary measure used to judge administrative change.

Within these complicated hospital settings patients are being treated, cared for and neglected. It is easy to see faults and almost as easy to suggest changes. Unfortunately, a hospital is like a jigsaw puzzle. The pieces must fit together. Any changes must be made so as to avoid disruption of the entire structure and must at the same time further the only legitimate purpose of the hospital, the cure of patients.

Specific suggestions directed toward the achievement of this aim will be presented under the headings "people," "money" and "public relations."

## PEOPLE

Trained people working in constant and intimate contact with psychiatrically ill patients must be comfortably housed, must have some chance for family life, some recreation, reasonable opportunity for promotion and some measure of security. They must also be constantly stimulated.

These fundamental requirements are already part of any thoughtfully planned hospital program and involve no change in policy. It is in regard to certain special groups of people that radical changes are necessary. We shall discuss these special groups under the headings of "medicine," "nursing" and "occupational therapy."

*Medicine.* In psychiatric hospitals there are two medical necessities, one clinical and one administrative. In the past a great premium has been

placed on administration. Promotional lines have lead toward superintendencies. Good clinicians have been forced, in order to achieve promotion, to become poor administrators. Poor clinicians, because they were good administrators, have been kept on as clinicians awaiting administrative openings. Patients have suffered.

**SUGGESTION 1. The chief clinical position, "clinical director," "chief therapist," "chief psychiatrist," whatever he is called, should rank in salary and quarters not more than 5 per cent below the superintendent. The position should be filled by promotion from the ranks of clinicians and should not lead to promotion to superintendent.**

Because mental illness feeds on interpersonal relations and flourishes or dies according to the quality of its diet, psychiatric hospital administration must remain psychiatric. The superintendent of a psychiatric hospital must be a medical person with long experience in hospital administration and intimate knowledge of psychiatric problems. Specialization of medical duties should, therefore, begin after one or two years of hospital experience.

**SUGGESTION 2. Young physicians, both men and women, who are interested in administrative psychiatry should be given administrative training and responsibility in each hospital group and department, including the supervision of maintenance, utilities and finance. With this training should go constant emphasis on the psychiatric implication of administration. The senior person on such service should rank just below the senior clinical officer and promotions should be to superintendent, not to the clinical service.**

Such divided responsibility, accompanied by dual lines of promotion, will come as a shock to hospital physicians who have been trained to be fathers and mothers to patients, disciplinarians to ward personnel, distributors of supplies, bosses of dining rooms, censors of correspondence and arbiters of public relations. Nevertheless, if psychiatrists in state hospitals are to practice psychiatry, they must give up their attempts to be all things to all patients.

Even with the aid of an administrative staff and the usual development of specialized medical and surgical services, state hospitals cannot hope, in the foreseeable future, to have enough psychiatrists to spend enough hours with enough patients. Some plan must be developed by which the influence of psychiatric skill can be brought to bear on a greater number of patients.

The obvious first step is to supply psychiatrists with well-trained secretarial assistance. It is poor economy to allow highly trained specialists to spend half their time on paper work.

A second step, which has been taken in many hospitals, is the delegation of routine admission procedures, history taking and so forth to trained social workers.

There is no reason why much routine family interviewing ("Does Janie need a new slip?" "How does John eat?" "What kind of letters shall I write?" "When can he come home?") could not be taken over by properly instructed nurses who could be constantly in touch with large groups of patients. This does not mean that the psychiatrist should avoid all interviews with relatives. It does mean that a skillful nurse could save a large share of the psychiatrist's time. Psychologists and psychiatrically oriented chaplains also belong in this plan, a plan designed to bring individual psychiatry to focus on individual patients.

This is still not enough. An entirely new type of worker is needed in state hospitals. Psychiatric therapy carried on by nonmedically trained persons in child guidance clinics and in psychoanalytic practice under psychiatric control has proved its value.

A number of personnel workers in industry, some workers in vocational guidance, some visiting teachers have demonstrated ability to carry out psychotherapy. In some state hospitals groups of patients, led by some recovering individual, under the direction of a ward doctor, have produced remarkable results.

A state hospital should provide the ideal basis for the development of such supervised psychotherapy, both with individuals and with groups. The basic idea would be to extend the contact between psychiatrist and patient by providing each psychiatrist with extra tongues and ears, particularly ears, and thus to make controlled psychotherapy available to large numbers of patients.

**SUGGESTION 3. "Psychiatrist's aides," who would serve as extra ears and occasionally as extra tongues for the psychiatrist, should be trained in state hospitals. The basic requirement would be personality. Specific training and method would depend upon the method and approach of the individual psychiatrist. Such "psychiatrist's aides" might well be chosen from former service men and women who had recovered from personal psychiatric illness with the aid of psychotherapy. There should also be suitable individuals among recovered civil hospital patients. Psychiatric hospitals have long neglected the valuable experience acquired by recovered patients.**

State hospitals tend to suffer from inbreeding. Fertilization from the outside is necessary for productivity. It should be purchased.

**SUGGESTION 4. Active psychiatric consultants and visiting psychiatric lecturers should be bought and paid for by every state hospital. Their lectures and ward rounds should be open to all medical, nursing and other professional personnel.**

*Nursing.* Nursing in a state hospital ranges from occasional and usually regrettable obstetrics, through acute medical and surgical nursing, to the care of patients whose physical condition no longer demands orthodox nursing skill.

The operating room, for example, requires all of a registered nurse's professional training. On wards for chronic bed patients, the nursing needs are still largely medical. On disturbed wards, the demand for psychiatric training and personality begins to exceed the need for those basic sciences which form so large a part of the present day training of registered nurses.

Finally, on many psychiatric services, little more technical nursing is required than in an ordinary household. But on these wards, if patients are to recover, there is need for psychiatric skill made available through workers chosen on the basis of personality.

The nurse on a psychiatric ward does not need to know how many bones there are in a foot, which organisms are gram negative or the dose of pilocarpine. She does need to know what to do about delusional material. She needs to recognize impending suicides. She needs to know what hate and fear and love can do to people. She needs to know psychotherapy. Beyond all she needs personality of a special type.

State hospitals have been hampered by the professional exclusiveness of registered nurses. They will

not sit at the same table with practical nurses or live in the same dormitories. Many hospitals have fostered this situation by means of courses for "graduate practical nurses" who are supposed to know a little about everything the registered nurse knows. They have been trained as ersatz models of the real thing and the registered nurse looks upon them, quite justly, as nonprofessional inferiors. In other hospitals, an attempt is being made to apply a coat of psychiatry to the outside of student nurses who usually picture themselves standing beside an operating table, a bed or a wheel chair, ministering to the needs of a suffering body.

For a long time to come the rare registered nurse who is also a psychiatric nurse will be too valuable as a teacher to be used on wards. We need, on our psychiatric wards, an ample number of professional helpers who can meet registered nurses as professional equals. They should take up the care of patients at the point at which psychopathology becomes more important than bacteriology.

**SUGGESTION 5. State hospitals should train "psychiatric counselors"; not nurses who could help with a delivery or assist in an operating room or set up an intravenous tray or weigh out a diabetic diet, but psychiatric specialists who could stand up as professional equals beside registered nurses and work with them in varying proportions, depending on the needs of the particular service. Their training should be radically different from that of registered nurses, not simply a modified copy with additions.**

*Occupational Therapy.* Occupational therapy must get out of its baskets and take off its rugs. Milking a cow is occupational therapy, so are dishwashing, coal passing, stenography, laboratory work and library supervision. Every task patients perform to keep a hospital running should be therapy, supervised by an occupational therapist. Part of the state hospital problem has been "patients working to help hospitals." Occupational therapy should create a group of patients working to help themselves.

**SUGGESTION 6. Occupational therapy should include all hospital tasks. Occupational therapists should be trained to meet this greatly extended responsibility.**

## MONEY

There will never be enough money to operate state hospitals lavishly. If enough money could be obtained to provide every possible facility for every patient on the admission service, on the medical and surgical service and on the convalescent service, there would be a gradually decreasing need for "chronic services" (I use these discredited words deliberately). Present day admission services are creating chronic patients.

State hospitals should build up their admission service with all available personnel and equipment, even at the sacrifice of other portions of the hospital, and should concentrate on additional funds for admission services rather than on attempts to raise the over-all maintenance allowance. Over-all annual per capita maintenance allowances as reported, for example, in the Census Bureau Reports give a distorted picture of operating expenses. Only part of every state hospital actually delivers "hospital grade" service. For those portions actually delivering such service "hospital grade costs" should be reported and requested.

One more observation in regard to money. Most state hospitals still cling to "salary plus maintenance." In practice this means that hospitals can only employ single, celibate or sterile people except in those few upper-grade positions which provide maintenance for the employe and his family. Most hospital employes are underpaid. Some of those who are given maintenance for families are overpaid. The cost of such maintenance is usually concealed in statements of over-all per capita costs.

**SUGGESTION 7. "Salary plus maintenance" should be abandoned. Employes should be paid living wages comparable to those in the community and they should then pay for their living.**

## PUBLIC RELATIONS

State hospitals are touchy and frequently defensive. Many are afraid of newspapers. Superintendents take visitors through wards in which the pillow cases have been embroidered by patients, let them look into the operating room, show off the occupational therapy class with 40 out of 3000 patients at work, possibly the kitchen when meals are not being served and often the immaculate dairy. They show off the best and avoid the worst.

Nothing has blocked progress more than the custom of dressing up hospitals for inspection. They should be undressed and served raw.

**SUGGESTION 8. Always show inspectors, governors, legislators and reporters the very worst conditions. Explain in detail why such conditions exist. Admit that state hospitals are forced to neglect some patients. The hospitals themselves must publish that fact before conditions can be improved.**

Hospital reports contribute to poor public relations. Only 18 per cent of all patients leaving state hospitals for any cause are reported as "recovered." Thirty-four per cent are called "improved." Such figures are published and the public feels that few patients ever get well. No one knows what "recovered" or "improved" means. Any hospital administrator knows that the class to which the patient is assigned often depends on the conscience or the disposition of the clinical director.

The terms, "recovered" and "improved," do not have a verifiable relation to fact. Actually, many patients return to the community. They are out of the hospital. That statement can be proved. Some take up their former occupations. That can be shown. Some take up less exacting employment. That statement approaches the verifiable. Some are unemployed. Other patients remain "in hospital," some usefully employed, some as conforming citizens and some as hospital nuisances.

**SUGGESTION 9. State hospitals should abandon the mystic words "recovered," "improved," "unimproved" and should tell the public what happens to patients in some such terms as "out of hospital, engaged in former employment"; "out, engaged in less exacting work"; "out, but unemployed," or "in hospital, usefully employed, cooperative, uncooperative."**

Nine suggestions have been presented. Any of these suggestions can be carried out at a level that is easily understood by the general public and by state legislatures. State hospitals cannot go far ahead of public opinion, but they can provide what the public demands. There is one final suggestion:

**SUGGESTION 10. Teach the entire public what it has a right to expect from state hospitals. The public will help you get it.**

# LEGAL HAZARDS of Inadequate Hospital Records

**HOWARD BURRELL**

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THE legal hazards of inadequate hospital records should be of particular concern to the small hospital for, if such institutions are derelict in any phase of their activities, such dereliction occurs most often in the field of charting. Neglect in this field is risky and costly.

The information that should be contained in a proper hospital chart has been fairly well standardized by judicial decisions. When hospital records become involved in a court proceeding, there is no special distinction in favor of the small hospital; the charts presented in court by the small hospital are scrutinized just as carefully and measured by just the same standards as are the charts produced by the large hospital. It is no defense to say that the hospital is only a small institution. The patient is certainly entitled to a proper recording of the important facts even in the small hospital.

### Must Contain All Factors

An adequate hospital chart contains all factors of both a positive and a negative character involved in and affecting the progress of the patient in the hospital, described in sufficient detail to enable one to ascertain from an examination of the chart all pertinent data. The chart should speak both of events that did occur and of services that were rendered the patient and of those that did not occur and services that were not rendered.

In a case tried in the Superior Court of Los Angeles County the sufficiency of the hospital chart was criticized on two major counts. The first count concerned the consent of the patient to a major surgical operation. The patient arrived at the hospital on the morning of the operation and the hospital records showed that her signature was attached to the usual formal consent to surgery. However, nothing was disclosed in the hospital records as to the time when this consent was actually signed, although the chart did show that within a short time after her arrival the patient was given a sedative.

It was comparatively simple for the plaintiff's lawyer to establish that the nature and quantity of the sedative administered would deaden the sensibilities of a normal person and the attorneys for the hospital were put to great difficulty when the patient testified under oath that up to the time she had been given the sedative she had not signed any document of any character! Every hospital should so maintain its charts that they demonstrate that the consent to surgery given by the patient preceded the giving of narcotics or sedatives.

The second important count was the difficulty caused by absence of a notation on the chart to the effect that the patient had *not* been given breakfast in the morning prior to the operation. One of the complaints of the patient was that she had suffered pneumonia and consequently tuberculosis, or rather the lighting up of an old tuberculous condition, by reason of the fact that she had aspirated some food while under nitrous oxide ether anesthesia.

The doctors, of course, were required to admit that breakfast is contraindicated prior to the administration of such an anesthetic but the patient positively stated that she had eaten breakfast before going into surgery. No one connected with the defense believed her, but the nurse on duty had disappeared and all the defense had to depend on was the hospital chart which had no tangible proof to dispute her statement.

Another outstanding deficiency in the keeping of hospital charts is the failure of some nurses to record the brief visits of the doctor to the patient, say, for instance, on his morning round of the hospital. If such a chart should be called into court for a critical examination and the question is asked of the superintendent of the hospital, "Isn't it usually and customarily required that the visits of the physician to the patient be recorded?" an affirmative answer is, of course, given.

### Did the Doctor Come?

If the court or jury finds no visits from the doctor to his patient mentioned on the chart, the natural and obvious inference is that the doctor did not visit the patient. Often three and four days pass without a record of a visit of the doctor, whereas it was well known that the doctor made daily morning rounds visiting each of his patients.

Most careful mention of the removal of foreign substances from the patient, such as drains and the like, and particularly of the number removed, is of the utmost importance. Sometimes in pus cases many drains are inserted and occasionally one or more will come out with the dressings. Any nurse who does not record this fact might well invite a most embarrassing inability to explain the situation in a court many months later. The celebrated California case of Heizman *v.* Koch dwelt for days on whether a drain had been removed at a certain time, and the chart was silent!

Countless malpractice cases against both hospitals and physicians involve tight bandages and casts; an accurate and clear record of the progress of the color of the patient in the affected parts would have been of great assistance and perhaps decisive.

The rule for the making of an adequate hospital chart should be that there is no fact too insignificant and no item too unimportant to record. However, in applying the rule just stated, one word of caution might be given. The rule requires the statement of facts and not the statement of conclusions.

Nurses sometimes are inclined to draw conclusions or to embark upon diagnostic procedures of their own. For instance, a nurse diagnosed a condition to be a burn and recorded it as such when, in fact, the condition was not a burn. What the nurse actually saw was a reddened area on the skin of the patient. The patient subsequently brought a malpractice action on the ground that she had suffered a burn and her case was considerably bolstered by the diagnosis which the nurse had placed on the chart.

In another instance the nurse recorded the statement, "The patient is moribund," on the chart. The patient was not given a transfusion and recovered damages by reason of the failure to administer it.

### Record Routine Treatments

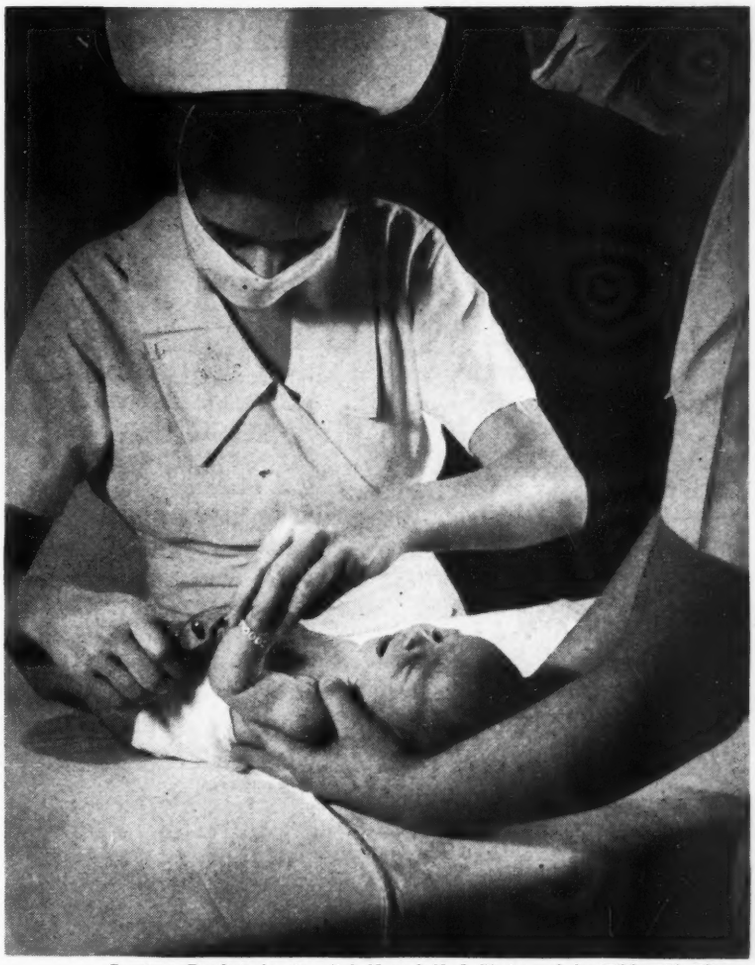
The most vicious circumstance with which lawyers are confronted in cases of inadequacy of hospital records is the failure to record matters which are considered to be routine, as, for example, the administration of ergot, pituitrin or both in obstetric cases. The fact that such procedure is routine makes it all the more necessary for it to be recorded on the chart.

It is not enough for a nurse who is being cross-examined as to why a certain nursing procedure was not set down on the chart to say, "Well, I know I did it because I always do it and that is why I didn't put it down." Lawyers hear this discouraging answer time after time. A slovenly chart is often worse than no chart at all because it is usually susceptible to the insinuation that it is an altered chart when examined in court.

Not only do adequate hospital charts protect the hospital, but the patient has the right to have available for his doctor a minute record of his case so that it can be viewed in perspective. The doctor has the right to have such a record so that he can discern and correlate circumstances in the course of the patient's progress which otherwise he might not be able to do.

The record or the chart may be the only protection available against a terrible error of judgment while the patient is in the hospital or a tragic mistake at any later time.

For example, a patient operated upon in Los Angeles about five years ago for an appendiceal abscess moved to San Diego and resided there for about five years when another attack occurred. He went to a new doctor who diagnosed his condition as appendicitis; upon being advised of the diagnosis, the patient told the doctor that his appendix had been removed. The doctor relied upon the patient's statement, did not proceed with an appendectomy and in a few days the patient died of a ruptured appendix. Had the hospital chart made at the time of the prior operation been available to the doctor the life of the patient would undoubtedly have been saved.



Courtesy, Presbyterian Hospital, Newark N. J. Photograph by William M. Rittase

**According to a California ruling the statute of limitations does not run against infants during minority and a child can maintain an action for damages sustained either before or after the cord is severed.**

Modern methods of making copies and of filing charts have materially reduced the problems incidental to their retention and storage. Charts should be retained for the legal protection of the hospital, for the scientific value and data that they may contain, for the statistical information that may be procured therefrom, for the benefit of the doctor handling the case and for the use of the patient in the future.

### Keep Adult Charts Five Years

Certainly, all charts covering the hospitalization of adult patients should be kept for at least five years after the discharge of the patient and, likewise, all charts affecting infants should be kept until at least one year has elapsed following the infant's attaining majority. This is the very minimum requirement.

A recent California case has reaffirmed the rule that the statute of limitations does not run against in-

fants during minority. Prior to this decision it was always thought that the rule in California was to the effect that only the mother could recover for damages to the infant prior to the severing of the umbilical cord, but this case lays down the rule that the child can maintain an action for damages sustained either before or after the severing of the cord. We can therefore expect malpractice cases to be brought many years after the event and under such circumstances that the hospital chart will be the only record available from which it can be ascertained what actually occurred.

There is also a growth in damage actions on the theory of a breach of contract or warranty by the doctor or hospital or on the theory of fraud or deceit; in such cases the one year statute of limitations applicable to actions for personal injuries does not apply. The statute of limitations in California for the breach of a written contract is four years following the accrual of the cause of action; for the breach of an oral contract, two years following the accrual of the cause of action, and for fraud or deceit, three years after the discovery thereof. It is apparent that the retention of hospital charts for only one year is insufficient.

It should not be left to the discretion of nurses, especially student nurses, to determine what should or should not be included in a hospital chart. Some rule should be fixed and some definite procedure should be established to ensure that certain standard facts are recorded in hospital charts. In the last analysis, whoever has charge of the nurses in a hospital should be responsible for causing the proper kind of a chart to be kept.

# Courtesy Smooths the Path

**GEORGE L. DAVIS**

Executive Director, Nassau Hospital, Mineola, N. Y.

EVERYONE who enters the doors of a hospital should be accorded courteous attention, for each individual is worried about himself or about someone for whom he cares.

**Admitting Clerks.** The initial contact with a patient, a visitor or anyone coming to the hospital is the important and lasting one. If this contact is unpleasant, experience has proved that often complaints, justifiable and unjustifiable, are registered from then on until the patient is discharged. Each person in the admitting office should express the attitude of the hospital by rendering warm, cordial, courteous, efficient and sincere service.

Following are a few suggestions to which, through your experience, you can add others:

1. Make no distinction among your patients. Treat the poor as you would the rich. Regardless of race, creed, color or financial status, the hospital's attitude toward all should be one of courtesy.

2. Try to get patients admitted promptly. Be brief. Admit critically ill or seriously injured persons immediately.

3. Explain financial arrangements carefully and diplomatically, especially the extra charges.

4. Do not discuss or mention unpleasant matters within hearing of patients, relatives or others.

5. Always answer telephone calls promptly and politely, letting the person know to whom he is speaking.

**Cashiers.** Govern yourselves by the following suggestions and others that your experience has proved worth while.

1. Bear in mind that there is an art in the collection of bills.

2. Never keep patients waiting at your window. They are on their way home and are rightfully anxious to get there.

3. Speak pleasantly to everyone who comes to your window. Never show irritation.

4. Always be willing to answer questions relative to bills. Do so diplomatically and with genuine and habitual politeness.

5. Remember that you have a difficult duty to perform and that the manner in which you do it reflects favorably or unfavorably on the hospital. Furthermore, remember that the effectiveness of your work shows up in your "daily proof sheet" and in other ways of which you are well aware.

**Telephone Operators.** You talk to many people in a day and most of the time you do not know to whom you are talking. It may be a relative of a seriously ill patient, a patient, a salesman, a member of the board of directors or someone who is interested in making a contribution to the hospital. You have unlimited capacity for being good-will ambassadors of the hospital.

Sometimes you may deal with people you think are rude. In the case of your co-workers, if they seem abrupt or rude, it is probably unintentional on their part. Perhaps, it is an outlet resulting from trying to solve problems of a troublesome nature.

**Information Clerks.** You are asked about everything imaginable, most of the time pleasantly but on occasion not so pleasantly. You know most of the answers, but when you are in doubt you know to whom the question can be referred. Never say "I don't know."

**Nurses.** You are the main good-will ambassadors of the hospital. Many times you can give more comfort to a patient by being courteous than through the medicines you administer. At all times remember that the welfare of the patient is in your hands. Try not to show it when you are annoyed. Many patients believe in the infallibility of nurses; by exhibiting too much of the human side of your nature you are likely to let your patients down. Plainly, "Keep your chin up."

**To All Others.** Each person working in the hospital, whether or not he comes in direct contact with patients, visitors or the public, is essential to the smooth functioning of the entire organization. If one unit does not function efficiently and on a high standard, it certainly will affect other departments. No matter who you are or what you do, let courtesy be uppermost in your minds at all times.

# The Voluntary Hospital Looks to the Future

**THOMAS PARRAN, M.D.**
Surgeon General
U. S. Public Health Service

IN MY thirty years as a public health officer, I have observed the vital part played by voluntary institutions in American life. Their first consideration, their continuing effort has been to meet human needs, directly and simply, in the spirit of Christian service. It is this very factor of direct action for the relief of suffering that has given the voluntary hospitals their pioneering tradition. In addition to doing their immediate tasks throughout the years, they have been sensitive to progress in medical science and the social changes which have accompanied their problems.

### Voluntary Hospitals Pioneered

It is not surprising, then, to find voluntary hospitals in the forefront of the modern movement to expand and improve hospital services in all parts of the country. They have taken the lead in planning a nationwide program of construction which, when authorized by the Congress, will represent a substantial step toward bringing our hospital plant to a level commensurate with the needs of the people.

The proposed National Hospital Program will go far toward modernizing our workshops of modern medicine. To provide all the new hospitals we need, to replace obsolete structures and to build the required rural health centers will cost much more than the estimated total of $700,000,000; at least ten years will be needed to complete the task. But we should come at least one third of the way under presently proposed legislation.

During 1945, the legislatures of 18 states passed laws establishing hospital surveys, and eight of these enacted laws providing for the administration of construction programs. Some states also adopted licensing systems for hospitals and related institutions; every state should do this. The need is as obvious as that for licensing physicians. Other states passed special laws dealing with the study of medical care needs for the entire population or for particular groups, such as the needy and the chronically ill. All these activities reflect the public interest in our hospitals and in the maintenance of high standards of service.

One of the most encouraging signs of the times is the interest in careful planning for social progress in our communities, for progress not only in the health fields but also in education and many others. The development of a hospital program is no light task. When we consider the enormous scope of such a project nationally, even within a state, we can recognize at once that it can be done only by beginning at the periphery, that is, in the community.

In turn, each institution is a separate starting point. As the plan is developed, community by community, it will be possible to fit the pieces together in a functional plan for the country as a whole.

While we are planning to bring the physical plant up to requirements, we should be planning also to improve the efficiency of service. Well-equipped buildings are only a part of the need. The sum total of knowledge and skills which the hospital offers constitutes the services essential for health and healing.

The history of our hospitals reflects the close relationship between the growth of medical science and the expanding concept of the hospital's function. Until fairly recent times, the hospital was thought of merely as a place for the sick poor to go, usually to die. More recently, as the specialties of surgery and anesthesia made their phenomenal advances, the need for surgical services (usually for acute conditions) overshadowed all other demands upon the hospitals. In the last two decades, however, the growth of diagnostic service and medical treatment has foreshadowed the modern concept of the hospital.

Today, a sick person goes to the hospital in order to get modern treatment, and he expects to get well. In the future, we shall expect the hospital, working hand in hand with the health department, to be the instrument for total community health equipped with the facilities and with the varied skills needed to promote health and prevent disease, as well as to treat the sick. Among leaders in the professions, there is growing agreement that only by this means can the science of preventive medicine be made fully available to the people. The progressive hospital, then, will begin now to develop a much closer relationship with its public health authorities, both in the state and in the community.

### Should Be Base of Operations

The rural hospital and health center, for example, may well become the base of operations for the local health department, the two providing an integrated service for prevention and cure. In several parts of the country, this concept is finding practical expression. At Bethesda, Md., the nonprofit Suburban Hospital Association operates a 100 bed hospital on the same site with a Montgomery County health center. All facilities were designed as integrated units.

At Bremerton, Wash., a county hospital and health center provide quarters for both services under one roof. A common laboratory and community clinics serve both institutions. Renton, Wash., has con-

Condensed from a talk at the 1946 convention of the National Association of Methodist Hospitals and Homes.

structed a modern hospital which is operated for the municipal government by a nonprofit organization.

In the past, we have been familiar with the administrative plan of caring for the sick poor in voluntary hospitals, with the county or municipality bearing some or all of the cost. In the treatment of venereal diseases, we are now going one step farther, illustrating the closer relationship of the community's hospitals with the public health program.

Rapid treatment of syphilis with penicillin has increased the demand for hospital beds in which patients, regardless of their economic status, receive the necessary treatments in about one week. When separate centers are not available, health departments are financing the operation of rapid treatment wards in general hospitals, both voluntary and public.

In the future we may expect to see similar arrangements made for the treatment of tuberculous patients in the early stages of their disease when recovery is most readily assured and for treatment of other diseases for which the public has accepted responsibility.

### Group Practice Is Developing

A further projection of the hospital's function in the future is development of the group practice of medicine. If we are to visualize the hospital as providing comprehensive medical service, it is clear that the institution must be the focus not only of modern equipment and facilities but also of shared medical knowledge, experience and skill.

As medical science becomes more complex, the physician is obliged to use more technical aids and more consultative advice. Thus, if the benefits of modern medicine are to reach all of the people, we must make it possible for doctors to work together in groups, pooling their abilities, the special knowledge of one supplementing the knowledge of the other. The hospitals are the logical centers for such service.

In fact, it is through the hospitals that the concept of group practice has grown. Our great university hospitals and many private centers, such as the Mayo, the Lahey and the Crile clinics, represent the development of group medicine to the peak of performance and prestige. On a smaller scale, we have many examples of group practice developed by the physicians of a community in cooperation with their local voluntary hospital.

As we plan for expanded hospital and health services in all parts of the country, which would provide complete medical and health care for all of the people, we should assume that group medicine will be practiced on a much wider scale than ever before. The voluntary hospital, looking ahead, can begin now to anticipate this trend. I venture to predict that it will be the accepted pattern of the future. Progressive institutions and the physicians associated with them are united in their belief that to improve medical care and to make it more widely available such planning and organization for the future are demanded.

As the hospitals have pioneered in the development of construction programs and in the growth of group practice, so also they have been leaders in the development of group payment for hospital services. At present, some 20,000,000 Americans are covered by voluntary Blue Cross hospital insurance, almost four times the number covered by voluntary insurance for the payment of medical costs.

Thus far, the rôle in which I have attempted to cast the voluntary hospital of the future has been on the presumption of present conditions and needs and of continued trends now operating. But you need to look even farther ahead in your planning. It is not too early to assume that we shall have in this country a nationwide system of prepayment for health care embracing all or substantially all of the people.

President Truman has recommended in his five point health program a nationwide system of prepayment for medical costs. He further recommended that the national medical care program utilize the voluntary organizations, including hospitals, agencies providing services and insurance plans, to the fullest degree consistent with the maintenance of standards and efficient operation. Congress now has before it legislation that would put into effect a medical care program, as well as expansion of public health services.

The reason for group purchase of medical care is protection of the individual against the unpredictable risks of illness. The nation's sickness risk is predictable and the costs of hospital and medical care can be estimated. Since the individual family cannot make such predictions and cannot budget the costs, it would seem reasonable to use the taxing power of the federal government in order to spread the costs equitably and ensure good care to all.

The President proposes that such a program be financed through "an expansion of our existing compulsory social insurance system" and through general taxes for uninsured groups. Proper use of these sources would obviously require that governmental and private organizations work together to assure to all groups, regardless of the source of payment, a high quality of health care.

Legislation is now before the Congress designed to carry out the President's program. We can assume that hearings will be held on these measures. Hospital groups, knowing the problem, will need to study carefully the proposed laws, be prepared to make constructive suggestions and consider how best these institutions with their vast wealth of experience can contribute most to the total objective: the best possible health care for all citizens.

### Discussion Centers on Methods

With this objective, none can disagree. It is time now to discuss methods. Here, there is much room for discussion among men of good will. Here, I hope it is possible for substantial agreement to be reached among spokesmen for the several health professions and institutions or, if agreement cannot be reached on all points, that the areas of disagreement can be narrowed, debated and presented to the public, which in the end will decide them.

What I am trying to say is that this is no time for blind dogmatism by proponents or blind opposition on the part of those who hold a contrary view regarding compulsory prepayment of medical costs. In a federal union like ours, there is a wide variety of methods which might be used in effectuating a nationwide system of medical care. These need to be studied dispassionately by those from whom the people expect leadership and light.

Our history shows that every great social issue has been surrounded by controversy. This is inherent in the democratic process. Recall, for example, the issue of religious liberty

in our Consitutional Convention or the debates in the early nineteenth century over public school systems. Then the issue was whether or not a child of poor parents should have the same opportunity to learn to read and write as other children for whose education the parents could pay. Once this issue was decided, it became a part of the American ideal.

I have faith that in this issue, too, like that of public education, we shall decide that every American shall have an equal opportunity for health. Such opportunity, of course, must be limited by biologic factors but not by economic considerations.

The instant problem is equally important; the issues must be analyzed and clarified and national policy must be voted on by representatives of an informed electorate. Through one system or another, I am confident the people will obtain higher standards of health care and that such care will be more widely available than it now is.

If we are to provide such services on a vaster scale than ever before, we shall need to draw upon all the experience we have had in the development of voluntary insurance against sickness and of compulsory insurance for economic security and in the provision of public medical care.

Basic to the accomplishment of this task are other elements of the President's program: the extension of public health services, the provision of mental health services, the expansion of scientific research and additional support of professional education in health and medicine.

### Hospital's Place Is Important

Although the hospitals are most immediately concerned in the proposed program for the construction of facilities, the voluntary hospital, like other qualified institutions, will have an important place in the total national health program: in medical care plans, in public health services and in research and education.

Despite the difficulties inherent in setting in motion such a total effort for health, there is no doubt that all of us working together can do it. Thereby, we shall be assuring to the American people one of the fundamental human rights in a democracy: "the right to adequate medical care and the opportunity to achieve and enjoy good health."

# Red Cross Recreation Service

## *answers the patient's need to play*

**MARION A. MAXIM and LOUISE F. STOLZ**

Staff Members, Hospital Service, Military and Naval Welfare Service
American National Red Cross

PSYCHOLOGY, education, psychiatry and social welfare recognize recreation as a part of normal living. An understanding of emotional needs has brought increased recognition of the fact that a balance between freedom and compulsion, between work and relaxation is essential in maintaining emotional health and physical vigor. Adults, no less than children, need to play if their physical and mental capacities are to function freely. They need to experience achievement in activities or relationships which have satisfying meanings for them. They need companionship with others of their own choice.

Physicians know that physical exercise and mental stimulation are needed to offset the regressive effects of illness and the disruption of normal pursuits. The place of recreation in convalescent care has been recognized by the fields of both internal medicine and psychiatry.

An awareness of the dangers of long periods of hospitalization in terms of lethargy and boredom resulted in the development by the Army and Navy of a program of reconditioning and rehabilitation because of its importance to the patient's recovery. Red Cross workers, in cooperation with reconditioning personnel, occupational therapists, special service officers and other hospital staff, supplemented the reconditioning program with additional recreational opportunities to meet the individual needs and interests of patients.

Services of the Red Cross, world encircling in scope, are made possible by the support of the American public. Equal in importance with financial support are the services of the many Red Cross volunteers. For the recreation program Camp and Hospital Councils provide materials and equipment, as well as entertainment. These councils, organized in more than 2000 communities, function as a central unit to channel community gifts and entertainment to the adjacent military hospitals.

Members of the arts and skills corps; hospital and recreation corps (Gray Ladies); the canteen, motor, staff assistants and production corps have given invaluable service to patients by assisting the workers who are responsible for the patients' recreation.

### Serve in 700 Hospitals

Service has been provided for patients in more than 700 military hospitals during World War II. These patients have come from various economic, racial, social and educational backgrounds and from diverse geographical areas. Wide differences in age and in interests and dissimilar reactions to illness, to military life and to regulations accentuate the problem of meeting the recreational needs of individuals and groups.

Careful planning and skillful leadership are needed by the recreation

Red Cross Photographs by Riordan

**Hospitalized Waves at the Naval Hospital, Bethesda, Md., borrow a checkerboard from the Red Cross recreation worker to help them while away the long hours of convalescence.**

worker who goes to a ward of 30 patients and finds, in one bed, a graduate student of philosophy from Yale; in the next, a man just learning to read or write; across the way, a trumpet player from a New York "name" band; in the last bed, a house painter from Keokuk.

Such diversity demands that the recreational opportunities provided for hospitalized servicemen and women include the majority of human interests. The program must be organized on the basis of extensive knowledge and experience, combined with cognizance of the patients' needs and desires.

In developing her plans, the recreation worker must consider the condition for which the patients are being treated. Patients with long-term illnesses, such as tuberculosis, rheumatic fever and serious orthopedic injuries, react differently from those who have upper respiratory infections, minor operations or sprained backs.

Within each group, psychological reactions vary markedly. The man with a broken leg generally knows that within a few weeks he will be up and about. His spirits are usually excellent; he feels like doing things and enjoys group participation. But the man with tuberculosis is likely to be despondent and feel that the future is dark for him when he feels tired and ill.

Men who have been in combat and have suffered mental or physical injury present still another problem in approach and understanding. As the worker builds a program for this group, she must appreciate the effect of combat experience and must consider many implications. Red Cross staffs have been alert to adapt suitable and satisfying recreation to the special disability groups, such as the hard of hearing, the blind, the amputees, the plastics, the paraplegics and the neuropsychiatric patients.

Ward programs are discussed with the medical officer in the light of individual and group needs and abilities or limitations. Here, music and crafts are brought to the bed patient. He is provided, also, with opportunities to do creative writing, to sketch and paint, to participate in quiz programs, to play games adapted to the ward situation, to be entertained by artists and celebrities who have donated so generously of their time and energies. The patient feels free to express his choice in the selection of recreation activity which, if it is at all possible, is provided for him.

Unlike most civilian hospitals, the military hospital has a large number of ambulatory patients who may leave the wards and with whom recreation can be planned in the recreation hall and lounge, in outdoor areas and in communities adjacent to the hospital.

Outdoor areas adjacent to the hospital have been utilized extensively. Concrete shuffleboard courts, horseshoe pits, tennis, badminton and croquet courts, picnic areas, outdoor stages and gardens have been developed. Trips to points of interest, to sports events and community entertainments have also been conducted.

Throughout the entire Red Cross recreation service, emphasis is placed on voluntary participation by the patient, with the approval of the medical officer. It has been demonstrated that the period of illness and convalescence has been reduced considerably when patients avail themselves of the various recreational opportunities.

One of the greatest developments in the Red Cross hospital program during World War II has been the cooperative functioning of the recreation worker and the case worker as members of the clinical "team." This integrated service has taken the form of constant referrals between the workers and has resulted in increased benefit to the patient. An excerpt from a Red Cross worker's report illustrates the results which can be produced by a close working relationship.

"An interesting example of cooperation between the social case worker and the recreation worker occurred in connection with a patient from an eye, ear, nose and throat ward. He came to the recreation worker's attention in an extremely depressed and introspective state of mind. This led her to ask his help in simple tasks in connection with the recreation program. He helped in the kitchen when parties were being held, prepared craft carts for Gray Ladies, painted signs, ruled charts and volunteered to assist in keeping the recreation hall in order.

"As he became acquainted, the young man developed a feeling of friendliness for the recreation workers. Eventually he revealed that his parents were ill and that he was desperately needed to help take care of things at home. At this point his problem was discussed with a case

worker and he was referred to her. Having already established confidence in the Red Cross through the recognition and responsibility given him by the recreation workers, he readily accepted the case worker's help with his difficulties.

"It was possible to arrange for the Red Cross chapter in the patient's home town to assist his family with its problems. The medical officer in charge of this patient stated that the combination of allaying his concern for his family and encouraging his participation in recreation had produced a marked improvement in his mental outlook and had speeded his recovery."

A more dramatic story reported by another worker concerns Corporal Brown, age 21, who had been in the Army for more than two years. He had been burned about his chest, hips and legs when the gasoline truck which he was driving exploded after a collision, killing all but three of the occupants. He had been hospitalized at various Army installations for fourteen months and when he was admitted to this hospital his morale was at a new low. He was cynical and his outlook was not improved when several days after his arrival he was unable to obtain the furlough which he requested because of the death of his sister's baby.

"Corporal Brown did not participate in Red Cross activities although he frequented the recreation hall. It was next to impossible to draw him into a conversation. This was a challenge for Red Cross workers. First, we talked to the medical officer, who was most understanding and anxious to help the patient find himself. He readily gave permission for the patient to be included on Red Cross picnics and other outdoor trips.

"The first time Brown attended a picnic, he said it was 'for want of anything better to do.' We noticed that he always covered his scars with a large bath towel when he came out of the water. When we called this to the medical officer's attention, he talked with Brown at great length, then told us that the patient was embarrassed about his leg which was shrunken and disfigured. The medical officer said that he was attempting to have the patient accept the fact that his scars made him no different from other patients. He expressed the hope that the Red Cross workers would help him in his efforts. Our cooperation was assured.

"The case worker and the recreation workers planned together how best they might do this. We found that he was not interested in any type of crafts but did like card games. We approached Brown one night when we were having a 'poker-smoker' to help us get the patients together. He was interested and later we learned he also liked pool. A pool tournament was arranged in which he won the first prize.

"From then on, Brown began to join in activities and one day came into the office to say that he had a problem. It was then we learned that his mother had died while he was overseas. His last allotment check to her had been returned but the money had not been refunded to him. The case worker was able to render a small service at this point and thus open the way for him to bring other problems to her.

"Since that time he has lost his cynicism and has become one of the most popular patients we have. His rare sense of humor is enjoyed by everyone in the recreation hall. He attends all Red Cross activities and no longer covers his scars but jokes about them."

The value of cooperative service by case workers and recreation workers in military hospitals has been so outstanding that we may expect its extension to civilian hospitals. One Red Cross hospital executive made the following statement:

"To the professional social case worker, one of the most challenging changes in the military hospitals in which we have worked has been the presence of the recreation workers. Most of us in civilian hospitals have not had experience in working with these specialists. In this hospital we have experimented with ward rounds, in which the case worker and recreation worker together have approached the patient, each interpreting the services she is prepared to give. This has made us simplify our vocabulary and delineate our areas so that the patient may have a clear idea about whom he should call when he needs a specific service.

"We have had referrals between case workers and recreation workers which have given both of us a sense of increased professional status. We have worked together on programs for special disability groups. . . . Those of us who return to work in nonmilitary settings will wish we had the recreation workers with us to enrich the program in our civilian hospitals. We have learned the value of recreation for patients."

**The recreation worker participates in this game with a veteran of Okinawa. The sturdy checkerboard that is in such demand was presented by members of the Junior Red Cross.**

# EDUCATION

**SISTER LORETTO BERNARD**

Administrator
St. Vincent's Hospital
New York City

HOSPITAL administrators and educators are agreed that educational planning in the field of hospital administration is beset with problems that are numerous and complex. Up until the present, university courses, the apprenticeship system and in-service training have been the means employed. But no one of these types of training has been found to be completely satisfactory.

The program briefly outlined in the present article is an attempt at a solution. It will be found to differ, in some major aspects at least, from the methods employed in the existing vehicles of training.

It is based on the belief that the ideal locale for training the hospital administrator is found not in the university exclusively, or in the hospital exclusively, but in a program that would achieve a rapprochement between the two: that would at once preserve all the intellectual factors that the classroom could provide, utilize all the practical experience that the hospital services could offer and, by the union of the two, effect an integrated course of training for the student.

It is believed that such a program of study and work could be covered in one full year. It is, in a word, an attempt to cull the best features of the university courses, incorporate the most effective elements of the apprenticeship and institute systems and, at the same time, avoid the limitations inherent in all three types of training. What is presented then is a mosaic or, better, a synthesis of the best current thought on the subject of training the hospital administrator.

This program was formulated to meet the specific needs of a definite group of students, namely, a selected number of Religious Sisters. It was developed with an eye to their specialized religious background and to the practical difficulties they would encounter in pursuing the more extended university course. There is no reason, however, why this program with minor adaptions would not be suitable for any group of students.

I labor under no delusion concerning the adequacy of this program. No exaggerated claims are made as to the results it will produce. I do not envisage the product as a trained and finished administrator. I simply hope to provide students with an opportunity to lay a sound, solid foundation of theory and practice in hospital administration. The program attempts to develop in them habits of thought that make for continuing growth and the mastery of basic principles of management with practice in adapting and applying these to particular situations.

**Objectives of Plan**

The objectives of the program would be as follows:

1. To provide an educational experience of one year's duration for a limited group of carefully selected students in which they would have the opportunity to learn, to develop and to mature in the practice of hospital administration.

2. To inculcate through this course of study and work the principles that underlie the main functions of the modern hospital, namely, the care of the sick and injured; the education of physicians, nurses and other personnel; the prevention of disease and the promotion of health; the advancement of research in scientific medicine.

3. To emphasize the importance of the hospital as the center of public health in the community and the need for the fullest cooperation with all existing health and welfare agencies in order that the best interests of the patient may always be served.

4. To show the need of certain personal qualifications which are not only desirable but essential to successful administration, such as tact, prudence, diplomacy, sympathy and patience.

5. To have the student take an active share in the fundamental tasks of administration, *i.e.* in the solution of problems of interrelation, cooperation and supervision in the major departments and services of the hospital. This will enable the student to familiarize herself with the actual day-by-day running of the hospital. She will see in operation the principles and theories that she is learning in the classroom.

6. To aid the student to emerge finally at the end of the year with the knowledge and ability to recognize the complexity of patient care, the intricacies of finance and the relation of the hospital to other allied professional groups and organizations.

7. To relate the religious life of the Sister administrator to the care of the sick through her administrations of charity and to develop in her the ability to inculcate in her subordinates the love of Christ as the first and principal aim of their hospital service.

**Direction of the Plan**

The administrative officers of the program would be directly responsible to the board of managers of the hospital.

In order to maintain the necessary balance and perspective among the numerous elements that enter into the field of hospital administration, an advisory board would be appointed. It would be composed of representatives of those fields that are considered to be most intimately related to the efficient management

Based on a thesis prepared for the American College of Hospital Administrators, August 1944.

# *for Administration*

***Here is a program of work and study that preserves the advantages of both classroom training and practical hospital experience***

of a hospital: philosophy, education, medicine, business administration, public health and welfare, social sciences, hospital administration and nursing.

This board, because of the breadth of its interests, would prevent the program from lapsing into an apprenticeship method and would maintain it on an approved professional and intellectual level. The administrator of the hospital would be a member of the board.

The group would constitute the administrative officers of the program and would, ultimately, carry the full responsibility for its successful conduct. It would be an advisory body to formulate policies, direct the course of instruction, supervise the plan of professional guidance and vocational counseling and suggest suitable lecturers in the various fields of study, and would supervise the length and distribution of classroom periods, seminars, conferences, round table discussions, field trips and the supervised experience in the various hospital departments.

To administer this program, the board would meet regularly, at least once a month. At this meeting, a summary of the activities of the program would be presented and reviewed. These reports would furnish the basis of a continuing system of progressive guidance and would present an opportunity for the board to maintain intimate contact with, and complete control over, every phase of the work. These reports would also be invaluable as a "running record" of the project itself.

The administrator of the hospital would have an integral part in the direction of this program. Her duty would be to have it function smoothly within the general administrative framework of the hospital. It would be her responsibility to prevent it from interfering with the orderly conduct of the various departments and services set up for the care and comfort of the patient. It would be her problem to impart to all who engaged in the program a sense of responsible participation in its objectives and in the successful accomplishment of its aims.

The administrator would prepare the various department heads to accept this plan by a series of staff meetings, which she would hold before the inauguration of the program and at which she would present a blueprint of its organization, an outline of its work and a preview of the way in which the practical experiences would supplement and reenforce the discussion of theoretical principles.

The administrator would indicate to the department heads the rôles they were to play in giving the student an adequate picture of the functions and the work of their respective departments and an appreciation of the interrelationships that exist between them and the general administration of the hospital.

In addition to this preliminary work with the department heads, the administrator would share her actual, day-by-day administrative experiences with the students in the course of their rotating assignments. She would work with them individually, beginning with the opening of the mail in the morning. They would be present at the individual conferences which the administrator holds with members of the medical staff, heads of departments, personnel and other groups, that commonly occupy the time of the administrator in the routine management of the hospital.

The students would accompany the administrator to various meetings, such as the board of managers, finance committee, executive and committee meetings of the medical staff, women's auxiliary, hospital staff conferences and various meetings held outside of the hospital, including local hospital and welfare organizations and other community enterprises relating to hospital administration.

The administrator would also conduct what might be called an administrator's workshop. In this workshop, she would meet the entire group of students semimonthly. Its purpose would be to develop in the student an appreciation of the many intangibles that go to complicate the work of the administrator. These intangibles are numerous and while it is essential for the successful management of a hospital to know how to cope with them, they cannot be adequately treated in any course of lectures. In this workshop, the administrator would analyze, step by step, the various thought processes in which she engaged while solving the actual complex problems that taxed her ingenuity during the year.

**Coordination of the Plan**

To ensure the proper coordination and integration of this combined program of study and practice, a full-time coordinating director would be appointed. She would hold the key position in the execution of this program and, for this reason, should be qualified by a broad cultural education, professional training and practical experience in the field of hospital administration.

The coordinating director would work in close conjunction with the advisory board and the administrative head of the hospital and would execute their orders. She would also confer, at least once a week, with the administrative head of the hospital and report the progress of the program to her.

A further responsibility of the coordinating director would be to keep in contact with all the lecturers who

had been chosen by the advisory board, to work out in detail with them the distribution, frequency and dates of their lectures and to coordinate their efforts.

She would offer guidance and direction to the department heads under whose tutelage the students are to receive their practical experience. She would hold regular weekly meetings with these department heads and with them would discuss the program of each student and the problems that might have been encountered.

The selection of the students, who would be required to hold either a bachelor's degree or a registered nurse's certificate, would be the joint responsibility of a special committee of the advisory board and the coordinating director. The latter would obtain credentials on the background, experience and previous education of the applicants. Whenever possible, she would conduct a personal interview with them.

### Orient Students to Hospital

It would also be her responsibility, after the students have been selected and the course begun, to devote the first few weeks to orienting the students to the hospital and its environment. The content of the lectures that would be given during this early part of the course would be introductory in character. Their aim would be to acquaint the student with the broader fields of hospital work and to give her a total overview of the numerous phases of this complex profession.

During this time, the coordinating director would hold frequent individual conferences to assist the student to adjust herself to her new field. She would ascertain the amount of experience the applicant has had in any phase of hospital or administrative work and, on this basis, give individual guidance and counseling to the student. It would enable her to adjust the course content to the individual differences of the members of the group.

It is believed that individual planning during this period would be particularly necessary because of the varied backgrounds, experiences and education of the students. For this reason, also, there would be flexibility in the emphasis that would be placed on the different phases of the individual work.

The coordinating director would arrange study tours of the laboratories, libraries and other essential services of the hospital, instruct the students in its geography, introduce them to the heads of departments and other staff members and acquaint them with the journals, periodicals and reference materials that deal with hospital administration.

Throughout the entire year, she would have an opportunity for continuous guidance and direction to meet the individual needs and problems of the students. One means of giving this guidance would be the regular weekly conferences which the director would hold individually with each student, at which the student would be expected to report on and to discuss work completed during the previous week in her lectures, departmental workshop, field trips and administrative experience with the hospital administrator.

The coordinating director, with the knowledge of the administrator, would draw up and supervise the program of rotating assignments to the various departments of the hospital. On the basis of the information which she had obtained concerning the background and experience of each student, and after a conference with the various department heads, she would determine the order which the student would follow in proceeding from department to department and the length of time she would remain in each. Both of these features would vary from student to student, depending on the individual's needs, desires and qualifications.

An important part of the students' work to be accomplished during their experience in each department would consist of the investigation and solution of some problem in hospital administration. This problem would be assigned by the coordinating director and carried out under her continuing guidance and help. The coordinating director would compile and correct the examinations to be given at the end of each quarter of the course and keep adequate records of the work experience and the academic achievement of each student.

The lecturers who would present the subject matter in this program would be trained and experienced administrators, teachers of hospital administration and its related fields and, in some instances, speakers who are neither administrators nor teachers but are fully competent to discuss the subjects assigned to them. The choice of these lecturers would be made by the advisory board after consultation with representatives of the American College of Hospital Administrators.

### Fields Covered in Lectures

The topics for the lectures would cover the following fields: hospital organization and administration; medical staff organization; nursing staff organization; ethical practices; admitting and discharge; dietary service; adjunct diagnostic and therapeutic facilities; special hospital services; public education and public relations; medico-legal aspects of hospital administration; financial administration and business control; cost reports and financial statements; budgetary control; credit and collections; insurance; personnel management; housekeeping, laundry and linen control; plant maintenance; group hospital insurance; hospitals and public health; trends in hospital administration and allied fields.

A distinctive feature of the program would be the work that would be accomplished under the supervision of the department heads in the various practice units of the program.

This would be an attempt to introduce the workshop technic and to realize a demand which has been expressed frequently in various articles in the field of hospital administration.

The head of each department selected for the units of practice would play the rôle of laboratory instructor. Her work would be to give individualized instruction to each student. She would break down the work of her department into units or problems of experience for the individual student. She would work with only one or, at the most, two students at any time on any one unit of work or problem. She would discuss the

theoretical aspects of these units of work, point out the various methods employed, suggest other possible technics and from a comparative analysis of these procedures endeavor to have the student familiarize herself with the underlying principles.

This problem, or unit of work, would not be attacked as an isolated unit of the work of the department; its relationships and the implications it bears to other departments and to the administration of the hospital as a whole would be given the major emphasis. This unit of experience would be supplemented by field trips to other hospitals, cooperating in the educational program.

From this combined experience, it is believed that the student will be able to formulate sound principles of hospital administration.

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# An Englishman Looks at Our Mental Health Service

**T. FITZROY KELLY**

Chief Lay Administrative Officer, Runwell Hospital, England

I HAVE read with the greatest interest the prize-winning essay on improving the care of psychiatric patients, published in the November 1945 issue of The Modern Hospital, and I consider that the authors have made a valuable contribution to this most important problem.

While it would be presumptious to claim that I am in a position to appreciate the full significance of the recommendations in the essay, I am the better able to do so because I have recently returned from a short visit to the United States during which I was privileged to inspect a number of psychiatric hospitals. Owing to the limited time at my disposal my visits were confined to hospitals in the Northeastern states; they are hospitals of good standing and, I believe, may fairly be regarded as representative.

## More Concern Revealed

The treatment of psychiatric patients in the United States is obviously becoming a matter of more concern and I hope that my own impressions of the existing service, which I recorded before I read the essay, and some comments on the improvements suggested by the essay may be of interest to readers of The Modern Hospital.

I was extremely disappointed in the standard of the state hospitals. The wards struck me as being comfortless; they were badly decorated, the furnishings of low grade. The conditions of the patients, their clothing, the food and food service all left a great deal to be desired. The hospitals were seriously understaffed, owing mainly to relatively poor rates of wages; the rate of expenditure was low. I have been an outspoken critic of English public mental disease hospitals but I have no hesitation in claiming that they are of a higher standard than their American counterparts.

One of the reasons for the unsatisfactory condition of the state hospitals is their size. In England it is recognized that the standard of the small hospitals cannot be equaled by hospitals of more than 1500 beds because they are so unwieldy, a view which is endorsed in the essay. The form of central control of several hospitals in a state appeared to me to limit the initiative of individual hospitals.

Centralized administration of groups of mental disease hospitals operates in only a few areas in England but where it does the same weakness of the system obtains. The positions of senior officers in English mental disease hospitals are free from political influences; such influences cannot but have most harmful effects on the administration of the state hospitals.

I was most favorably impressed by the psychiatric departments of the general hospitals where incipient cases of mental illness receive either out-patient or in-patient treatment which may avoid the necessity for their admission to the state hospitals. Few general hospitals in England have such departments. The treatment of psychiatric patients in general hospitals has been opposed by most psychiatrists because, I believe, they fear that their personal prestige and the prestige of their mental disease hospitals would suffer.

Another feature of the United States' service which is in advance of England's is the psychiatric institute for the advancement of teaching and research. England has been scandalously backward regarding research into mental diseases.

The essay's general plan for improving the treatment of psychiatric patients by the establishment of a mental health center and a psychiatric hospital in each area of suitable population appeals to me as bold and realistic. It emphasizes the advantages of completely separating the short-term and long-term patients, a plan which has not found favor among the majority of psychiatrists in England. I feel sure that such a service ultimately would reduce the proportion of psychiatric patients needing long hospitalization.

## "Village Plan" in England

I was particularly interested in the proposed "village plan" for the psychiatric hospital because, broadly, it follows the lines of England's most modern public mental disease hospital opened in 1936. This hospital consists of a number of detached units each accommodating from 25 to 100 patients, classified according to the nature of their illness; the total bed capacity is 1000.

Other buildings are provided for the various services as envisaged in the essay with one important difference: there is no central cafeteria for ambulatory patients. Patients' meals are served in each unit in a dining room which is in keeping with the homelike atmosphere of the unit.

The hospital has proved to be highly successful and, in my opinion, in conjunction with a mental health center and in affiliation with general hospitals would go far toward providing the ideal mental health service.

I should like to express the hope that the splendid efforts being made by The Modern Hospital for the improved treatment of psychiatric patients will meet with complete success and that in the future the United States will have a mental health service worthy of such a great country.

# *Hospital Veterans*—Welcome Home!

***American hospitals want their veteran employes back and are making a place for them, a survey shows, and most veterans are better employes now***

LIKE American industry generally, hospitals are welcoming back their employes and staff members who went away to war. The returning veterans are finding that their jobs have been kept warm for them. They can step right back into the old routine, or a different one if they prefer, usually at a better salary than the one they were getting when they went away.

If there are important exceptions to these general rules for returning hospital employes, they do not show up in the recent survey on this subject conducted for the Small Hospital Forum. The only major difference of opinion develops in connection with a question about the value of the employe's war experience.

### They Are More Valuable

Most hospital administrators feel that the special skills developed through Army or Navy training, and the experience of war generally, have made their veteran employes more valuable to the hospital than they were when they left. Yet there are a few who find the returning veterans unstable, unsettled and unsure of themselves and, therefore, less satisfactory as employes.

In the latter body of opinion, however, the feeling is general that the difficulty is transitory and that these people will ultimately settle down to steady work. "Give them a chance!" is definitely the prevailing sentiment, even about those whose performance is unsatisfactory.

Nurse veterans were mentioned as a special group by several of the hospital administrators who participated in the forum. The fact that many nurses are not returning to their old jobs in hospitals is noted.

"I doubt that more than 20 per cent of those who left will return to us," one administrator states, "and only 10 per cent have returned to work with us so far. Yet we would be glad to get our nurses back and would give them as good or better positions than they had before the war. We would pay present salary rates, which are about 20 per cent higher than they were when the nurses left us."

War-time marriage of nurses has changed the picture, several administrators say, mentioning this as one of the chief causes for the failure of nurses to return to their old jobs. And one nurse administrator, at least, takes a dim view of the immediate future with returning nurses:

"It will take some time for Army nurses to turn out a day's work equal to that done by civilian nurses during the war period," she says sharply. "All civilian nurses cannot be first lieutenant supervisors! Army and civilian nursing are as far apart as the poles." Only time will tell whether or not these nurses have gained or lost by their war-time experience, this administrator then acknowledges. "I believe they will adjust," she concludes.

Other comments about the nursing group add to the impression that war has caused the most disruption in this area. "Some nurses do not wish to return to nursing." "Most of our nurses either have married or are unsettled as to what they wish to do in the future." "More than half have married." These are typical observations.

The previously mentioned feeling that employes coming back from war are less satisfactory than they were before, because of general instability, probably develops from a few experiences with individual employes, the forum indicates.

"We've had several servicemen engaged for hire," one administrator relates. "Everything seemed satisfactory in the arrangements, but they changed their minds about coming. In several instances they came, worked a few hours or a day—and we heard no more of them. They seem very unstable, and it will probably take time for them to adjust their lives. Of course, we are anxious to be of help."

### Some Are Still Restless

"We have found them rather difficult," says another administrator of the returned veterans. "They are restless and discontented and do not seem to have adjusted themselves to civilian life. We feel that they are not as good employes as they were before going into the armed services; haven't seen anything yet to indicate that they've gained anything."

The majority opinion, however, is on the other side of this question. Most of the administrators replying on this point feel that returning veterans are much better equipped for good performance on the job than they were before. "They have acquired some useful experience," one reply states. "They've gained special skills and technics," says another. A third adds details:

"One colored man employed in our dietary department was a storekeeper in the service. He showed improved ability to arrange our stores of food neatly and responsibility in attending to his duties. This was di-

rectly traceable to the experience he had in service."

Every hospital heard from gives the returning veteran his old job if he wants it or offers him a choice and places him at his own preference. If necessary, the person who has filled in while the veteran was away is shifted to another job when he returns, but no hospital reports the necessity of dismissing such replacement personnel.

"We're so short of all help as it is that we can always solve the problem to everyone's satisfaction," is a common comment. In every case, too, veterans are enjoying the salary increases they would have had if they'd stayed on the job. Rates generally are up, of course, and most hospitals report that they are simply paying returned veterans the going wage for the jobs to which they return.

While one or two hospitals report that a great majority, 75 per cent or more, of employes who left to go to war are back or have been heard from and expect to come back, many more institutions anticipate that half or more of those who left will find other employment instead of returning to the hospital. From 25 to 50 per cent of those who went away are expected back in most cases. Most hospitals kept in pretty close touch with employes while they were gone and are informed about their plans for the future.

# Three-Cornered Service

## *Diaper Service to Hospital to Baby*

**MARION CAHN**

DURING the war, the special laundry and delivery service initiated by the diaper services helped to avert critical shortages of diapers when hospital laundries closed down over week ends. The service also was an important time and labor saver for reduced hospital staffs which faced the greatly increased needs of the maternity divisions, according to reports from authorities of hospitals that used the services.

In addition to delivery, diaper service includes laundering under sanitary conditions. Delivered in bundles of 100, the diapers are distributed three times a week or more often according to the requirements of the individual hospital. A metal deodorant container is included for use as a disposal pick-up unit.

In metropolitan areas diaper services are available for rush emergency deliveries anytime around the clock.

The diaper services as members of National Institute of Diaper Services, a national trade association, are constantly on the alert to improve their product. One advance was the introduction of a special organic chemical during the laundering process which forms "a zone of inhibition," in the terms of the industry. Many attribute the steady decrease in the number of incidents of diaper rash to this method.

When labor shortages threatened to curtail the efficiency of the service, 60 leading hospitals and members of the medical profession appealed to the War Department. As a result this industry was classified among the essential war-time organizations.

### Veterans Coming Back

With the end of the war, the adjutant general's office gave the go-ahead signal for the speedy release of former employes of diaper services. This measure was agreed to after many appeals from hospitals and doctors had been received.

"We need this service badly, war or no war," advised one hospital, expressing a general trend.

Although no actual figures are available to indicate the amount of time and money saved by hospital maternity divisions through this specialized service, the growth of the industry over the last eleven years is striking.

In New York City and its five metropolitan boroughs 60 per cent of all babies born there are supplied by diaper services. It is estimated that between 150,000 and 175,000 infants are born annually in the city.

Out of 110 metropolitan hospitals, 65 per cent report the use of diaper services for filling their maternity ward requirements and more than 5000 doctors throughout the country indicate that they recommend such service to mothers of infants.

The record also shows that from 15 to 18 per cent of all the babies in metropolitan areas continue to be attired by the diaper services after they are taken home from the hospital.


**Lieutenant Gilber, like many other veterans, is learning the diaper business first hand by attending the National Institute of Diaper Services Advisory Committee meetings. Here the former A.A.F. pilot is shown with a small customer from Brooklyn.**

# Progress report on interracial relationships

# *Courtesy Privileges* for Negro Physicians

**ROBERT G. WHITTON**
Administrator, Alexandria Hospital, Alexandria, Va.

TWO years have passed since the Alexandria Hospital of Alexandria, Va., took unprecedented steps in interracial relationships by admitting colored physicians to its courtesy staff. The passing of time has served to justify the expectations of those who sponsored such a move and to bring out the weaknesses along with the strength.

Our experiences will be of little interest and of little value to those communities of the North and West. They will not understand the existence of what appears to be two separate communities. They will not understand segregation. They will not have to cope with the problem.

### Local Needs Are Vital Factor

To the southern communities contemplating this move, we cannot say that our experience can serve as a pattern for them. We recognize the factors to be different in every community, every hospital, every white and colored medical fraternity. We recognize that all the *local* factors must be considered and that our action was taken on a purely local basis in the interest of better medical-hospital service.

Summarizing the steps leading up to the action, we find an expanding hospital within an expanding community thinking in terms of service for the whole community, colored and white. The basic conception was better medicine and better hospital training for those who for years had been deprived of this facility. To the leaders in the move in Alexandria, another hospital for colored patients, staffed by colored physicians, was not the answer. They felt it would only result in a small inadequate building, poorly equipped and expensive to operate. There would be a duplication of diagnostic facilities which were already available.

The way had been paved for this action by a number of circumstances, some of which might be peculiar to Alexandria, but which undoubtedly exist to a certain degree within every community. In order to appreciate fully the significance of the action, the background of the city of Alexandria must be known.

Alexandria is a pre-Revolutionary city, dating back to 1749. As such it has passed through all the history of the state and nation, contributing many illustrious sons to the causes. George Washington called it his "home town," maintaining a town house, voting, being a member of Christ Church and the Friendship Fire Engine Company, and depending on it for medical services. Doctor Craik and Doctor Dick, two of the three attending physicians at his death, were from Alexandria.

During the same period others prominent in early American history passed along its streets, George Mason, General Braddock, John Paul Jones. The War Between the States brought out the superlative character of Gen. Robert E. Lee, who lived and received his elementary schooling in Alexandria, before entering West Point. It was not until World War I that it began to grow perceptibly, with the real impetus coming in the early 1930's. Gradual growth was implemented by an impact of war workers in 1940, when the population doubled within three years. At present it lists conservatively 72,000 persons within a small territorial boundary, with about 12 per cent of these colored.

This review shows that Alexandria was and is a city of history and tradition, but also one of tolerance and understanding. When our action was given front page publicity within the local and metropolitan newspapers considerable commendation accompanied it from citizens of all races and ranks. It has been accepted.

Not only Alexandria but the Alexandria Hospital must be understood. Attached to our main building is the Alexandria Community Health Center, conducting all phases of clinic work, both colored and white. During the course of its history, it recognized the usefulness of the colored physicians and brought them into the clinic, working alongside of white personnel, paid and volunteer. In fact, the experience gained here played a large part in the subsequent action by the hospital.

### Segregation Maintained

In the hospital proper, complete segregation is maintained. Out of 191 beds and 44 bassinets, there are 28 beds for adults and eight bassinets within the colored section. These are staffed by colored graduate nurses and paid aides under white supervision. Colored Red Cross nurse's aides have also assisted during the past trying days in carrying the load of this section. These were trained at our suggestion.

While segregation as practiced makes the approach to the problem a little easier in some respects, we must point out that segregation is expensive. It does not permit the flexible use of the same quality of facilities by white patients whenever the demand in the Negro section is lighter than in the white sections. It is just as if two hospitals were being run under one roof, with a low occupancy figure in the one affecting the total occupancy of the whole. A full colored staff has to be maintained, stationary within the department and free from assignments throughout the house.

Privileges of medical practice granted by the board of directors, upon recommendation of the medi-

cal staff, were limited to the care of medical patients. Before action was taken members of the colored medical profession were approached and the possibilities were indicated to them. They were called into a meeting with the president of the medical staff, the president of the board and the administrator. A frank discussion of the ramifications of the move was held, so that a full understanding in advance of the rights and privileges might be had.

We jointly agreed on limitations to courtesy privileges in medicine, facing the possibilities of full acceptance by the various working groups realistically. We agreed that the colored physicians could not treat white patients, that they must be limited to the section as provided. We agreed on full use of the diagnostic facilities, full use of the doctors' library and attendance at their staff meetings and at symposiums.

### Negro Clinic Work Continued

The clinic work of the Negro physicians was to continue uninterrupted. They were to make application to the medical staff and be passed upon on the same basis as white applicants. In this connection the five men admitted in 1943 and the one admitted since that time are all graduates of approved medical schools and presented acceptable references.

The medical staff and the board of directors fully appreciated the importance of the move, feeling confident that the level of medicine within the colored community would be raised by it. The white medical fraternity accepted them readily and fully. The acceptance by the nursing staff was slightly less enthusiastic. This was particularly true in the operating rooms and the delivery rooms when expansion of privileges into these departments was under discussion.

An understandable reason is the fact that the physician in these rooms is in charge of the field, whether operative or obstetric, presenting a situation difficult of immediate solution. On the other hand, general duty nurses on the floor and in the emergency room proceeded to work along with these men in a satisfactory manner.

Having the problem of full acceptance makes the solution more desirable. From our point of view this will come when comparable facilities are provided, properly staffed.

A poll of the colored physicians having privileges indicates that the plan is working 75 per cent satisfactorily. One of the six indicates that the unsatisfactory 25 per cent is partially their own fault and partially the fault of factors over which they and we have no control.

One factor is our medical staff organization, wherein all staff cases are cared for by the white active staff. Regardless of the physician involved, whether white or colored, if a case comes into the hospital as a charity or part-pay case it is assigned to "staff service." Within the colored community there are few who can afford the status of private patients.

It can readily be seen that this prevents the colored physician from managing the case which must come into the hospital on "staff service." He can, of course, observe and watch the progress of his case and, at times, make suggestions based on his knowledge of its history. This was not true in the past when the colored physician lost his case at the hospital entrance and never knew what was done or whether the patient lived or died. The problem is now being carefully considered by the medical staff.

Another problem is the limitation on obstetrics and pediatrics. Surgery does not enter too much into the picture, except for minor work, because none of the present men is qualified for this privilege. When privileges were granted it was contemplated that full privileges in obstetrics and surgery for qualified men would eventually be attained, but the progress toward it must of necessity be orderly. It will come as the further expansion of the facilities makes it practicable to include them.

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# Nurses Need

## *Personnel Training, Too*

**MARY J. DUNN**

Senior Nurse Officer (R), Division of Nurse Education
U. S. Public Health Service

WHY is it desirable for certain groups of nurses to obtain training in personnel relations? It is recognized that sound personnel administration is essential to the smooth running and management of any organization.

Experts in personnel relations point out to us, and we all know from our own experience, that there is in the management of every organization the consideration of effective, safe and economical methods and procedures and, what is every bit as vital, the aspects of human interest, cooperation and morale. All of the foregoing aspects are as implicit in any hospital, school of nursing and university situation as they are in modern business and industry. It is increasingly recognized among nurse personnel that a healthy degree of stabilization and optimum functioning within an organization are usually in direct relation to the personnel policies and practices of such an organization. It is realized also that sound personnel policies and practice do not just happen but must be established and maintained under wise guidance and leadership. This, in turn, calls for training in leadership and personnel management. This type of training has not been emphasized sufficiently in the past as a vital phase of the training of nurse supervisors and administrators.

Consequently, when Dr. Frances Triggs, personnel consultant of the American Nurses' Association, inquired if Bolton Act funds allocated to universities for the various ad-

## Universities and Colleges Offering Advanced Nursing Education Programs

| STATE | UNIVERSITY OR COLLEGE | CITY | CODE* |
|---|---|---|---|
| California | University of California | Berkeley | 1,3,4 |
| | University of California | Los Angeles | 1 |
| | San Francisco College for Women | San Francisco | 3 |
| Colorado | University of Colorado | Boulder | 1,3,4 |
| District of Columbia | The Catholic University of America | Washington | 1,3,4 |
| Georgia | University of Georgia | Athens | 3,5 |
| Illinois | University of Chicago | Chicago | 1,3 |
| | Loyola University | Chicago | 1 |
| Indiana | University of Indiana | Bloomington | 1,3 |
| | St. Mary's College | Holy Cross | 3 |
| Massachusetts | Boston University | Boston | 3,4 |
| | Simmons College | Boston | 1 |
| | Clark University | Worcester | 4,5 |
| Michigan | University of Michigan | Ann Arbor | 1 |
| | Wayne University | Detroit | 1,3,4 |
| Minnesota | University of Minnesota School of Nursing | Minneapolis | 2,4 |
| | Department of Preventive Medicine and Public Health | | 1 |
| Missouri | St. Louis University | St. Louis | 1,3 |
| New Jersey | Seton Hall College | Newark | 1,3,5 |
| New York | St. John's University | Brooklyn | 1,3 |
| | University of Buffalo | Buffalo | 1,2,4 |
| | New York University | New York | 1,3,4 |
| | Teachers College, Columbia University | New York | 1,3,4 |
| | University of Rochester | Rochester | 3 |
| | Syracuse University | Syracuse | 1 |
| | Russell Sage College | Troy | 2,5 |
| North Carolina | University of North Carolina | Chapel Hill | 1 |
| Ohio | Western Reserve University | Cleveland | 1,3,4 |
| | Ohio State University | Columbus | 3,4,5 |
| Oregon | University of Oregon | Portland | 1,3,4 |
| Pennsylvania | University of Pennsylvania | Philadelphia | 1,3,4 |
| | Duquesne University | Pittsburgh | 1,3 |
| | University of Pittsburgh | Pittsburgh | 1,3,4 |
| Tennessee | George Peabody College for Teachers | Nashville | 1 |
| | Vanderbilt University | Nashville | 1,2 |
| Texas | Incarnate Word College | San Antonio | 1,3 |
| Vermont | University of Vermont | Burlington | 3,5 |
| Virginia | Medical College of Virginia (Program for Negro Students) (Program for White Students) | Richmond | 1 |
| Washington | University of Washington | Seattle | 1,3,4 |
| Wisconsin | Marquette University | Milwaukee | 1,3,4 |

*Code

1. Program to prepare public health nurses.

2. Program to prepare assistant clinical instructors and head nurses only.

3. Program to prepare personnel in schools of nursing and nursing services. In most instances these programs are designed to prepare for dual functions, for example, clinical instructor in a school of nursing and supervisor of a clinical department in a hospital. The number of different programs offered by these institutions also varies.

4. Program includes one or more advanced clinical courses or a series of advanced clinical and related courses in one or more clinical nursing fields, such as psychiatry, pediatrics, orthopedics, medicine and surgery.

5. Partial program offering a limited number of related courses but offered in an institution in which a complete advanced program is not yet developed.

vanced nursing education programs might be used to encourage training in personnel administration, the inquiry was favorably considered. Information was then sought from the universities that were participating in the federal grant under the Bolton Act to determine which of these were offering training in personnel administration. The information obtained appears in the accompanying table.

Selected graduate nurse students preparing for positions in leadership have been encouraged to include in their postgraduate study at least a certain number of related courses in the field of counseling and personnel administration. In all probability a number of such graduate nurse students should be encouraged to major in this latter field.

### Personnel Training Included

In the accompanying recently compiled list of universities offering postgraduate programs and for which Bolton Act funds have been allocated for the current fiscal year, practically all the universities listed offer programs or a series of courses in personnel guidance and administration.

After Japan surrendered, President Truman set Oct. 15, 1945, as the final date for admissions to postgraduate programs under the provisions of the Bolton Act.

It is assumed that many of the Army and Navy nurses returning to civilian life will seek opportunities for further preparation, including work in the field of guidance. These nurses are eligible for scholarship aid under the provisions of the G.I. Bill of Rights.

Information regarding other scholarship aid for postgraduate study can be obtained from the nursing information bureau of the American Nurses' Association, 1790 Broadway, New York 19, N. Y.

## Conferences at Queen's Hospital prove that

# DEPARTMENT HEADS Have Their Own Ideas

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FOR many years Queen's Hospital, Honolulu, T. H., has had an administrative council which has helped the administrator in solving problems and in deciding major matters of policy. It is composed of the administrator, the medical director, the director of nursing and of the school of nursing and, from time to time, such other department heads as may be called on individually to give their opinions on matters in their own fields.

This small body usually meets once each week in the administrator's office for sessions which last for about ninety minutes. The fact that no topics are barred and that the group is small enough so that the members can figuratively take off their shirts and argue vociferously for their ideas has made these conferences invaluable to the administrator and, consequently, a source of strength to the hospital.

### Problems Came Fast

As myriads of apparently unsolvable problems arose during the war —and they came thick and fast after the problem of casualties on December 7—it became increasingly desirable to obtain the opinion and advice not only of the administrative council members but of everyone who might have an idea. Proposed war emergency plans affecting the entire hospital were talked over informally with each of the department heads individually, and it was discovered that department heads often had good ideas on all sorts of subjects even out of their own fields, ideas that the administrator was awfully glad to get!

It became apparent that much might be gained by formally drawing all of the department heads into a conference or meeting at which certain problems could be presented to them for their collective thinking and plans and procedures already determined could be explained personally to those who were responsible for putting them into effect.

The first of these meetings, now referred to as "executives' and department heads' conferences," was held in October of 1943 and served as an organization meeting. As these were to be considered in the nature of cabinet meetings the administrator assumed the chairmanship, a position he has held ever since. The purposes which it was hoped that the meetings would accomplish were outlined to the group roughly as follows:

The foremost objective, of course, would be to raise the standards of the hospital by improving its service and methods and the knowledge and ability of its key personnel, *i.e.* the executives and department heads. The conferences would contribute to this objective (1) by increasing the understanding and background of the members as to general hospital problems and as to the functions of departments other than their own; (2) by serving as a forum for the exchange of ideas as to where problems existed and how they might best be solved; (3) by permitting a face to face explanation of the new plans, policies, procedures and methods as finally adopted; (4) by bringing misunderstandings out into the open so that they might be clarified; (5) by acquainting the department heads personally with one another, thus increasing liking, respect and good felowship among them; (6) by promoting understanding among departments; (7) by increasing coordination and esprit de corps, and (8) by so doing to develop unity of purpose and action.

A few simple rules governing the conferences were drawn up. One established the time of the regular meetings as being 10:30 a.m. on the second Friday of each month, the meetings not to exceed ninety minutes in length, with the administrator having the authority to call special meetings as required; another established the order of business, *i.e.* approval of minutes, agenda, new business, announcements; still another set up an agenda committee, and the fourth and last stated that it would be the duty of each executive or department head to attend the meetings unless he had a valid excuse for not doing so, in which instance he was enjoined to send his official second in command.

### Meetings Are Informal

Since then 22 regular monthly meetings have been held, but no special meeting has ever been called. The meetings are held in one of the rooms of the school of nursing and are kept as informal as possible. At first everyone sat in a circle around a large table but since that involved rearranging the chairs, both before and after the meeting, it was soon given up in favor of facing the black board (most useful adjunct), the chairman and the principal speaker.

A round table grouping would probably be preferable but in this warm climate that will have to wait until a room is available in which the furniture is permanently set up that way. In the meantime we hold on to as much informality as possible by talking while standing or sit-

ting on chair or table as preferred, smoking when the urge is felt and interposing such appropriate comments, short of heckling, as come to mind.

To date the only difficulty experienced in running the meetings, aside from two or three spats of temper, has been to end them on time. Somehow official closing time always finds someone giving vent to thoughts that at least a few of the members want to hear in spite of the fact that the hunger of the inner man is calling the rest.

Subjects for discussion have never been lacking. The agenda committee, consisting of the administrator and two others, collects subjects from the various members between meetings and makes up a schedule, which is then sent out to all members, together with the rather full minutes, a few days before the meetings.

In actual practice not too many suggestions for discussion have come from the members. When a member suggests a subject, in general he is called on to present it, although not always, as others can frequently present it from a better angle and we do not want anyone to be afraid to bring up subjects for discussion.

### 75 Topics Presented

A summary of the topics presented and discussed in two years shows that there was a total of 75, of which 31 (41 per cent) were problems calling for general discussion and the giving of opinions by the group; 27 (36 per cent) were explanatory talks to help the members in their daily work, covering such subjects as hospital policies, plans, procedures, organization, personnel functions, forms and administrative orders, and 17 (23 per cent) were educational or informative talks to give the department heads a broader background of understanding of hospital problems, operations, services and activities.

Of this total of 75 topics, 48 (64 per cent) were presented by, or the discussion was lead by, the administrator or his administrative assistant; 17 (23 per cent) were presented or discussion was lead, about equally, by the personnel, nursing, dietary, housekeeping, maintenance and business departments, and 10 (13 per cent) were presented by the other and smaller departments. As yet, no outsiders have been asked to give

## DEPARTMENT HEADS GIVE THEIR VIEWS

A very good thing - offers an opportunity to learn what other departments are doing, to talk things over, bring out weak points and see how we can improve on them.

A confounded bore most of the time! — though occasionally valuable information is obtained in the way of explanation of procedures that help in doing one's work.

A very good thing. Gives an opportunity to blow off steam and plant seeds of new ideas. Like all such conferences there is often too much talk and wasted time but that is unavoidable.

I think they are excellent - each department head learns what other departments do for the patient. You realize you are only a cog in a big machine

## ON THE VALUE OF MONTHLY CONFERENCES

It's very sound administration. Organizations that don't have conferences are behind the times. Serves as a meeting place of minds. Should be well run and avoid drivel. Elected chairman should rotate quarterly. Last quarter hour should be used to sum up material presented and decisions reached.

A lot of good stuff comes out although at times it is boresome which is probably unavoidable in such a program. Feel that agenda is padded sometimes.

Enjoy them tremendously they are mentally exhilarating — but I do not feel I obtain much practical information for use in my work. Wouldn't miss them for anything.

The idea of exchanging problems and explaining one's own department is good. Subjects should be of general interest and not private problems of a strictly one department nature.

talks or lectures to the group although the idea is looked upon favorably and almost certainly will be followed up in the coming year.

In spite of our conference rule that all department heads and executives should attend or, if unable to come personally, send substitutes, attendance at the meetings has averaged only 16.9 persons per meeting, or 77 per cent of the 22 eligible to attend.

The titles of those eligible to attend are as follows: administrator, administrative assistant, director of nursing and of the school of nursing, educational director of school of nursing, first assistant director of nursing, director of dietetics, executive housekeeper, assistant housekeeper, business department manager, chief of income division, chief engineer, personnel director, supervisor of orderlies and service personnel, director of volunteers, assistant purchasing agent for stores, chief pharmacist, medical director and director of laboratories, director of radiology, medical records librarian, director of social service, director of occupational therapy and chief physical therapist.

### Doctors Have Less Interest

Inevitably, the agenda have consisted almost entirely of administrative rather than medical matters with the result that the two doctors in the group have found little to interest them and have rather consistently failed to attend the meetings. Excluding the doctors the attendance has averaged nearly 85 per cent of the other members.

No account of these conferences would be complete without a statement as to what the members think of them, and so before starting to write this article the opinion of each member was obtained. All except two who were absent on vacation were approached in the same fashion with identical words asking a nonleading question (what do you think of the departmental conferences?) and with the promise of anonymity.

I was primarily interested in getting first impressions only and am convinced that the opinions given were entirely frank and honest and represent a fair evaluation of the conferences. Eighteen out of the 20 questioned believed that the idea of holding conferences is good and 16 said in one way or another that they had found them profitable, 14 stress-

ing the educational value with particular emphasis on the value of learning about other departments.

Seven mentioned the value of being able to exchange or pool ideas, three welcomed the opportunity to know other department heads better and three believed that it increased esprit de corps. Others expressed favorable impressions on other points which cannot be summarized. While nine offered no criticism at all, 11 had criticisms or suggestions for improvement of one sort or another.

Two of the total group thought the idea was poor and the time spent in the conferences wasted, one believing that it would be more profitable to call such conferences only when some important problem of general interest arises. One other person declared that while she did not feel that the conferences helped her in her work she enjoyed attending.

Seven of the criticisms centered on the idea that the conferences were often too long with too much unnecessary talk and too much straying from the subject at issue. (Excerpts from the unvarnished comments of some of the participants are reproduced on pages 88 and 89.)

In future every effort will be made to meet these criticisms by shortening the conferences to not more than an hour and a quarter, by hewing closely to the line of discussion and by presenting only topics of general or at least widespread, interest. Our experience has shown that these conferences on the whole are worth while and profitable to us.

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# THE COMMUNITY WILL BENEFIT FROM A *Hospital Council*

**A. C. SEAWELL**

Administrator
City-County Hospital, Fort Worth, Tex.

THE first question that should be asked by the hospitals in any community that is contemplating the organization of a council concerns the need for such an organization. To determine the extent of that need a survey of hospital and health resources should be made in the community, followed by an estimate of community requirements that remain unsatisfied.

The questions then can be stated: Is the necessity for meeting these local problems beyond the ability of one hospital to handle effectively, and will internal benefits result from an exchange of experience and information? It would be most unusual to find a locality which could not answer both questions in the affirmative.

With management becoming more complex and with government entering practically every field of human endeavor, it is now an urgent necessity that all efforts be unified in the interest of better hospital care. If this is true, what can a hospital council accomplish collectively that cannot be done on an individual basis?

A report made in 1933 to the A.H.A. Council on Community Relations and Administrative Practice by a committee appointed to investigate the subject stated that a local hospital council is "an agency designed to promote intelligent planning and coordination in the field of community health service. It seeks cooperation to prevent waste and to increase efficiency. It recognizes the autonomy of its hospital members and is interested in promoting their growth and development along rational lines and in obtaining for them necessary community support."

The interpretation made then is just as good today for it clearly demonstrates the unselfishness of the movement and the broad principles upon which hospital collective effort is founded.

The general aim of a hospital council should be divided into two major classifications, namely, responsibility to the community it serves and responsibility for improved internal administration of each hospital's affairs. While, in general, the main implication under the first classification is to encourage the best possible diagnostic and therapeutic hospital service at the lowest possible cost, specifically, there are many results that can be accomplished, as follows:

1. Promotion of higher ideals of hospital administration.
2. Improved public relations.
3. Support for, or opposition to, certain legislation that affects hospitals and public health.
4. Encouragement of Blue Cross plans.
5. Elimination of unhealthy competition among hospitals.
6. Collective bargaining power, especially as applied to governmental agencies.
7. Participation in community hospital and health surveys, or studies of other matters of public interest affecting hospitals.
8. Coordination of hospital relations with health, social and welfare groups.
9. Cooperation in community hospital planning.
10. Cooperation with hospitals of other communities.

The second aim of the council, relating to the improvement of internal administration of hospitals, covers the following:

1. Establishment of uniform statistics and accounting.

2. Dissemination of information concerning rates and costs of various hospital services.

3. Adoption of uniform administrative procedures, such as visiting hours, staff regulations, vacations, sick leave, professional discounts.

4. Reasonable conformity in rates for similar services.

5. Uniform minimum and maximum wages paid for comparable work.

6. Cooperative action on credits and collection.

7. Joint investigative services.

8. Cooperative purchasing of equipment, food and supplies.

9. Joint banking facilities for the financing of patients' accounts.

10. Central personnel office.

11. Cooperation in eliminating promiscuous hiring of other hospital employes.

12. Central ambulance service.

To this list of aims many others can be added, according to the local situation.

### Creates Bond of Friendship

While every move taken by the council should point toward ultimately improving the service received by the patient, at the same time many other values appear, not the least of which is the mutual cooperation resulting from a sympathetic meeting of minds. The inevitable bond of friendship and understanding creates a formidable front and, as a result, much can be accomplished.

The council's responsibilities to the community are great and should be clearly understood by those whose duty it is to guide the destinies of the council and direct its course into useful channels.

One hospital administrator writes: "There is no question in my mind that our hospital council has been well worth the time and effort necessary to maintain it. There is much good to be obtained when representatives from all the hospitals sit down together and discuss mutual problems and become acquainted with the individuals who manage the different institutions. Soon we realize that our difficulties are, in many instances, more or less identical and from that realization a spirit of cooperation grows."

Another administrator admonishes: "It is my personal opinion that hospital councils can contribute

largely to the development of hospital service on the basis of community need. There has not been a close enough relationship among hospital administrators and many of the boards of trustees have not come to full appreciation of the functions which hospitals should perform in the community. Unfortunately, there is too much of the competitive spirit still existing among hospitals, too much isolationism."

The requirements of any community are usually obvious and should be classified by degrees of urgency and possibility of attainment. There are many problems of a local nature, outside the ability of any one hospital to handle effectively, that actually demand group action. Many times it is one of these local situations which motivates the organization of the council and provides the immediate stimulus for collective effort.

### Meet at Hospitals

In the average community it is suggested that the meetings of the council be held at the various member hospitals in rotation for the sake of acquainting members with the institutions represented. Frequently, the incentive of a noon or evening meal will add to the attendance record. At such meetings the president of the board of trustees or the chief of the medical staff of the host hospital can be invited to say a few words.

Speaking of the board of trustees and medical staff, it is suggested that the council membership embrace representatives from the board and from the medical, nursing and dental professions, as well as representatives from the community chest, council of social agencies or their counterparts, and, finally, members-at-large representing the public.

The American Hospital Association suggests a model constitution and by-laws which can be modified or enlarged to suit the local situation. It cannot be too strongly stressed that officers must be selected with a great deal of care and that they represent persons who will work enthusiastically for the best interests of the council.

The admonition of Dr. Harvey Agnew of Toronto in a paper which he gave many years ago is so timely that a portion of it is quoted here:

"Hospital councils should not be merely paper organizations, mere afternoon teas where perfunctory letters to the mayor can be authorized between sandwiches and anything of importance referred to committees which never meet." He contends for real objectives and live officers. He says further that "platitudinous vows of cooperation are of little value unless backed by a willingness to work for common good, to place community first, to support council activities wholeheartedly and to undertake no development or policy which would be detrimental to other institutions or unnecessary for the community."

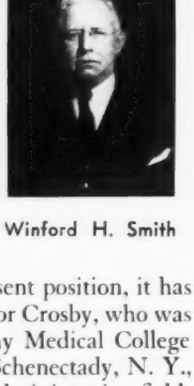
### Council Must Work

There is nothing more effective than a live council and nothing more useless than a dead one. Unless the membership is willing to accept its responsibility and discharge its duty completely, a council cannot hope to build for the future and earn the respect of those with whom it comes in contact. There is nothing more disheartening than a council which avoids responsibilities, yields to selfish pressure and never completes an undertaking. Fortunately, such councils are few in number, but where they do exist they do not have the respect of the other agencies nor do they justify the support of the community.

Recently, a bulletin has been prepared by the committee on subdivisions of the Council of Association Relations of the American Hospital Association entitled "Organization of Local Hospital Groups." No article on the organization of a hospital council would be complete without reference to this bulletin which so adequately covers the situation. It is urged that any community contemplating the organization of a council write to Kenneth Williamson, secretary, who will be happy to provide this suggested guide.

## About People

### Administrators



Winford H. Smith

**Dr. Edwin L. Crosby Jr.,** assistant director of Johns Hopkins Hospital since 1940, has been appointed director to succeed **Dr. Winford H. Smith,** who will retire April 1 after thirty-five years in his present position, it has been announced. Doctor Crosby, who was graduated from Albany Medical College in 1933, practiced in Schenectady, N. Y., until he entered the administrative field. He has been active in various institutes for hospital administrators and was recently appointed chairman of the American Hospital Association's Council on Education.

Director of Johns Hopkins Hospital since 1911, Doctor Smith was a member of the original editorial board of The Modern Hospital, which he served for many years following its establishment in 1913. An article written by Doctor Smith appeared in Vol. 1, No. 1 of this magazine in September 1913, the first of many valued contributions. Doctor Smith is a graduate of Johns Hopkins medical school; prior to his appointment to the hospital there he was medical superintendent of Bellevue Hospital in New York City and, earlier, superintendent of Hartford Hospital at Hartford, Conn. He was chief of the hospital division on the staff of the Surgeon General, U. S. Army, during World War I, and president of the American Hospital Association in 1916.

**Harold T. Prentzel** has resigned as business manager of Friends Hospital, Philadelphia, after eighteen years' service. For the last four years, he has been administrator also of the White Haven Sanatorium, White Haven, Pa., which is now expanding into the 240 bed tuberculosis unit of Jefferson Medical College, Philadelphia. Mr. Prentzel, who will remain at both hospitals for several months while his successors are being chosen, is a member of the committee on surplus property of the American Hospital Association and, in addition, represents that organization as a consultant to the War Assets Corporation. He is chairman of the organizing committee for the Commission on Hospital Care in Pennsylvania, has held the offices of president and executive secretary in the Hospital Association of Pennsylvania and is now editor of the *Bulletin,* publication of the state association.

**Dr. Joseph S. Drabanski** has returned to Chicago State Hospital, Dunning, Ill., as superintendent after forty-three months' service in the Army.

**John H. Morf** has been appointed assistant to the superintendent at Stanford University Hospitals, San Francisco. Recently released from active duty with the Army, he held the rank of captain in the Medical Administrative Corps and served in hospital administration and personnel work.

**Lt. Edmund J. Shea** has returned to his former position as assistant administrator of Indiana University Medical Center, Indianapolis. During his three years in the Army, Lieutenant Shea commanded the patient detachment at Tilton General Hospital, Fort Dix, N. J., and later was assigned to Thomas E. England Hospital, Atlantic City, N. J.

**Dr. Henry N. Pratt** has accepted a post at Memorial Hospital, New York City, in a few months he will become executive director of the new Cancer Center, now under construction.

**Maj. Wilbur C. McLin,** who was recently discharged from the Medical Administrative Corps of the Army, has assumed his duties as assistant administrator at Jewish Hospital, Cincinnati.

**Mrs. Cassie D. Shievers,** superintendent of Red River County Hospital, Clarksville, Tex., has resigned because of ill health and **Mrs. Thelma Greer** of Dallas, Tex., has been named her successor. Mrs. Shievers has been in the nursing profession for twenty-seven years.

**Col. Warren A. Colton,** chief medical officer of the Veterans Administration Hospital, Hines, Ill., since September 1944, has been promoted to manager, according to an announcement from the office of the Administrator of Veterans Affairs. The V.A. regional office, formerly housed in Hines Hospital, is being moved to a central location in Chicago, and **Robert D. Beer,** manager of the combined hospital and regional office, has been designated as manager of the Chicago regional office.

**Dr. Lewis G. Beardsley,** manager of the Mount Alto Veterans Administration Hospital, Washington, D. C., for more than thirteen years, and recently a special medical officer in the central office at Washington, has been named manager of the veterans' hospital at Newington, Conn. His predecessor, **Myer Schwolsky,** is manager of the regional office which was recently moved to Hartford.

**Fred J. Loase** has been appointed administrator of Presque Isle General Hospital, Presque Isle, Me.

**John F. Barker** has resigned as administrator of Vicksburg Hospital, Vicksburg, Miss.

**Franklin D. Carr,** who was recently discharged from the U. S. Marine Corps, is the new superintendent of Door County Memorial Hospital, Sturgeon Bay, Wis. Mr. Carr held the rank of captain at the time of his discharge.

**Frank B. Adair** has been awarded the first administrative internship established at Sydenham Hospital, New York City, under its new ruling of including hospital management in its program of training hospital personnel. He is said to be the first Negro to win this recognition in any voluntary hospital in America. Mr. Adair, who completed a six months' fellowship in hospital administration at Sydenham, was graduated from Morehouse College, Atlanta, Ga. He attended Harvard University's Graduate School of Business Administration and subsequently taught at Langston University, Okla. He has had professional experience also as chief business officer at Arkansas State College, business manager of Dillard University, New Orleans, and as production manager and administrative officer at Tuskegee Institute, Tuskegee, Ala.

**Liala I. Johanson** is the new superintendent of Lake Forest Hospital, Lake Forest, Ill.

**Jesse K. Morrison** has resumed his former post as administrator of Carrie Tingley Hospital for Crippled Children, Hot Springs, N. M., after serving three years as captain in the Army Medical Administrative Corps. Mr. Morrison served as control officer at LaGarde General Hospital, New Orleans, and more recently as director of personnel.

**Gladys Brandt, R.N.,** formerly administrator of People's Community Hospital at Eloise, Mich., has been appointed superintendent of Detroit Medical Hospital, Detroit.

(*Continued on Page* 172)

# HEADLINE NEWS

## Altmeyer Calls for Disability Benefits in Social Security

WASHINGTON, D. C.—Extension of present social security coverage to include all gainfully employed persons and provide disability benefits in addition to old-age insurance was urged in a report to the House Ways and Means Committee by Arthur J. Altmeyer, chairman of the Social Security Board, on February 25. Under the Altmeyer proposals an additional 21,000,000 persons would be added to the social security system, including farmers, domestic servants, government workers, self-employed people and employes of nonprofit hospitals and educational institutions.

The Altmeyer recommendation for inclusion of permanent disability insurance in social security was supported by a statement pointing out that disability affecting the earning power of a family head works as a great hardship on the family as do death and old age, benefits for which are presently included in the social security schedule.

The proposals also included an advance of the maximum benefit from $80 to $120 a month.

## Bradley, Stelle Confer on Criticism of V.A.

WASHINGTON, D. C.—Differences between Gen. Omar N. Bradley, Veterans Administrator, and John Stelle, national American Legion commander, over the quality of medical and hospital care given in veterans' institutions have been partly resolved in a series of meetings and conferences held during the past few weeks.

A public statement by Stelle indicating that his sharp criticism of Bradley's administration had been intended only to call attention to procedural difficulties and did not reflect on Bradley personally was made February 27.

Acknowledging that the Veterans Administration faces many severe problems in extending high quality medical care to thousands of veterans, General Bradley stated, "We at the Veterans Administration have a tough job, and we're doing our best. We have had more than 1,600,000 discharged veterans from this war reported to us who are entitled to care. We have only 60 per cent enough doctors. We do not have nearly enough hosiptals or attendants. It will take two years at least to complete urgently needed hospitals."

## A.M.A. Establishes Agency to Coordinate Voluntary Medical Prepayment Plans

Formation of Associated Medical Care Plans, Inc., an independent agency which will function to coordinate voluntary medical prepayment plans in all parts of the country, was announced by the American Medical Association at a press conference in Chicago on February 15.

The new agency was established following months of study of medical care plans by the association's board of trustees and Council on Medical Service, it was stated. The first function of "Associated Plans" will be the establishment of standards of acceptance for voluntary medical care plans. Plans meeting the approval of the Council on Medical Service will be entitled to use the seal of acceptance of the American Medical Association in advertising and on policyholders' certificates.

Details of the approval were not announced. However, it was indicated that, in order to qualify, plans must have the approval of local, county or state medical societies. The medical profession in the area must also assume responsibility for the medical services included in the benefits, free choice of physicians must be maintained and the patient-physician relationship must remain undisturbed.

In response to a question, Dr. Morris Fishbein, editor of the association's *Journal,* said that approval standards would also specify a minimum return in benefit payments to subscribers. The exact amount that subscribers in approved plans may expect to receive in benefits was not revealed.

The approval program does not differentiate between nonprofit prepayment plans for medical care actually operated by state or county medical societies and private sickness insurance plans underwritten by insurance companies. "The principles of such insurance contracts should be acceptable to the Council on Medical Service and to the authoritative bodies of state medical associations," the A.M.A. statement declared.

In announcing the formation of Associated Medical Plans, embracing A.M.A. proposals for nationwide sickness insurance on a voluntary basis, association officers restated the entire national health program sponsored by the A.M.A., as follows:

1. Higher standards of nutrition, housing, clothing and recreation to be sought through individual and community effort, with appropriate governmental aid when needed.

2. Provision of adequate preventive medical service through competent public health departments controlled at local levels.

3. Provision of adequate prenatal and obstetric care for all mothers, with federal aid furnished through local agencies for those who need financial help.

4. Adequate medical care throughout infancy, including scientific nutrition and immunization services, provided through local child care stations aided by tax funds.

5. Proper facilities for diagnostic care and hospitalization furnished by community agencies or local government, except where careful study indicates a genuine need for federal aid.

6. The national network of voluntary medical and hospitalization prepayment plans to be integrated under Associated Medical Care Plans, Inc.

7. Medical care, including hospitalization, for all veterans, utilizing the physician of the veteran's choice.

8. Establishment of a National Science Foundation to encourage and coordinate medical research.

9. Continued growth and encouragement of volunteer philanthropic health agencies, such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis and other foundations.

10. The widest possible dissemination of information regarding the prevention and treatment of disease, to be undertaken by public health departments, medical associations and school authorities.

## Seek Income Tax Relief

WASHINGTON, D. C.—Representative Clare Luce has introduced a bill to amend the Internal Revenue Code so that physicians, surgeons and dentists would get a deduction on their income tax for work devoted to charity. The Internal Revenue Code would be amended to read: "That commencing with the taxable year, 1946, physicians, surgeons and dentists shall be allowed an additional credit as a deduction on their income tax equal in terms of percentages to that portion of their time each year which is devoted to charity, free clinic work and/or public research work."

# "Third Party Plan" for Veterans' Care Approved by A.H.A. Mid-Year Conference

The principle of a third party or intermediary agency to facilitate the hospitalization of veterans in civilian institutions was approved in a resolution adopted by the mid-year conference of presidents and secretaries of state hospital associations in Chicago February 8. Blue Cross plans, public health departments, hospital associations or councils, community funds and similar agencies were suggested as the logical groups to serve in the intermediary capacity.

This action grew out of a statement from the Veterans Administration some time ago expressing preference for dealing with hospitals through such third party arrangements, and out of the contract that has already been made between the Veterans Administration and Michigan Blue Cross. Earlier action by the A.H.A. Council on Government Relations and the board of trustees recommended the third party arrangement. It was also recommended that payments to hospitals for veterans' care be established on a cost basis using the E.M.I.C. or an equivalent formula.

The conference was addressed at an evening meeting by Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* who reviewed trends in the distribution of medical care. Doctor Fishbein predicted that voluntary medical and hospitalization prepayment plans in the United States would succeed to a point which would make participation in this field by federal agencies on a compulsory basis unlikely.

Dr. A. C. Bachmeyer, director of study for the Commission on Hospital Care, reported progress on the hospital surveys now being made in most states. Doctor Bachmeyer discussed the relationships between large general hospitals and other types of institutions involved in the care of the sick, as the need for revising these relationships is brought out in the study of existing health facilities. Maurice J. Norby, director of research for the commission, reported on the methods being used for coordinating survey data and Dr. D. B. Wilson, U. S. Public Health Service surgeon assigned to assist the commission study, outlined the various types of organizations and methods of finance that are being used by survey groups in the various states.

The state surveys are stimulating interest in hospital licensing, it was reported by Dr. Charles F. Wilinsky, chairman of the A.H.A. committee on model licensure law. Ten states have licensing laws now, Doctor Wilinsky said, and the American Hospital Association favors the adoption of similar laws in all states. The association has formulated a model bill incorporating many of the best features of the laws now in force, he stated.

Surplus property disposal was discussed briefly by J. Russell Clark, secretary of the Council on Government Relations, who reported that formation of the War Assets Administration is expected now to speed the long-sought release of property which may be needed and used by hospitals.

Dr. Albert W. Snoke, chairman of the Council on Hospital Planning and Plant Operation, stated that the roster of accredited hospital architects drawn up by the A.H.A. in cooperation with the American Institute of Architects was to be issued shortly and would consist initially of about 40 architects—a group that should soon be augmented as the listing is used by hospitals. Guy J. Clark, chairman of the Council on Administrative Practice, outlined plans to revise the A.H.A. Manual on Hospital Accounting.

Fifteen thousand physicians returning from service with the Army and Navy have expressed a desire for hospital residency training, Dr. Robin C. Buerki, chairman of the Council on Professional Practice, reported, while there are only 1500 approved residencies. Doctor Buerki said there is danger that pressure to expand the number of residencies may result in dilution of their educational quality. The presidents and secretaries were urged to discuss the residency program with member hospitals of their state associations and urge careful expansion to make adequate training programs available for veteran physicians.

## Seek to Prevent Strikes

WASHINGTON, D. C.—A House Resolution introduced February 14 would have the Committee on Labor investigate proper and equitable means to prevent any interruption of work in hospitals and any other industry or establishment whose continued operation is necessary to life and health. The resolution would prevent strikes in public utilities and in industries involved in the processing and transportation of food. In the course of its investigation, the committee shall give full attention to special compensation, pension rights and other forms of security to workers in such industries.

## Hospitals May Apply for Tuition Costs for Physician-Veterans

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Veterans Administration has ruled that otherwise qualified physician-veterans pursuing advanced training as resident physicians in hospitals are eligible for subsistence benefits and that approved hospitals are eligible to apply for tuition remuneration. Training contemplated in connection with residencies and fellowships is not "training on the job" but is in the nature of institutional training. This applies to all acceptable residency hospitals whether or not they are affiliated with a medical school.

There are several bases on which a hospital may request payment. Hospitals requesting payment on the basis of an institution whose established tuition is inadequate compensation may be paid at the rate of $15 per month, or a total of $180 for a course of 52 weeks. The course of residency training usually covers a period of fifty-two weeks. When payment is requested on the basis that both the tuition and the alternative charges permitted are inadequate, the hospital will be required to deduct the value of services rendered by the individual from the cost of teaching personnel and supplies for instruction in arriving at the compensation to be paid for training.

It is the responsibility of every participating hospital to maintain an educational program of high quality fulfilling established and generally accepted standards for such work. No hospital is justified in requesting payment in connection with enrollment of veterans in a residency program unless such hospital offers a definite educational program, the Veterans Administration warns.

## Plan Medical Library Building

WASHINGTON, D. C.—Plans are afoot for the erection of a new building to house the Army Medical Library, according to an announcement of the Surgeon General's Office February 15. The estimated cost is $10,000,000. A request for funds will be included in the War Department estimate for the fiscal year 1947, scheduled to come before Congress. The building will be located on land named as part of the proposed postwar development of East Capitol Street from the National Capitol eastward to Anacostia. A board to review all matters relating to the new building has been set up.

# Let's Look at the Record

**E. M. BLUESTONE, M.D.**
Director
Montefiore Hospital
New York City

MANY noble deeds are done in the hospital, in spite of the multiple restraints of ill-considered policies, rules and regulations which sometimes sit heavily on the statute books. The good that is in the hospital worker of high or low degree, and this holds particularly true for the doctor, responds promptly to distress heedless of such restraints and what has so aptly been identified as "the letter of the law."

A severe code of hospital behavior is destined to defeat its purpose in the long run besides being an unreasonable burden on personnel memory at awkward moments. In Utopia we shall hope to see mutual aid at its best, coming into play under a spirit of freedom among intelligent and sympathetic workers, protecting everyone who is suffering from, or threatened with, ill health. Meantime, what is the optimum in hospitals toward which their trustees should strive or, for the specific purpose of our thesis, what kind of trustee is most likely to achieve it.

### Records Mirror Progress

We can illustrate our point by a visit to the medical record room of the hospital, for it is here that one can find the mirror to medical progress in the institution. Here lies the proof of achievement after the obligation of the hospital to the patient is thought to have been discharged. Trusteeship can be applauded or condemned by the evidence here discovered. It is in the record room that the trustee can take the measure of the members of the visiting staff without ever making the personal acquaintance of any of them.

Did the patient get a square deal? You will find the answer here, even if someone is trusting to memory and avoiding your scrutiny. If the patient recovered, you will learn, for the benefit of others, the process by which this happy event took place and, if he did not, his record should be even more stimulating and challenging. It will indicate many urgent questions requiring an answer. You can calculate the cost in money as well as in misery if you will consent to examine and appraise the medical records closely.

The clinical audit, carried out by or under the authority of a conscientious trustee, will reveal many helpful hints, directly or indirectly, about the bedside management of the patient and his problems. The medical record can, indeed, cry out in the name of an unfortunate patient, pleading against the recurrence of a tragedy.

The record room is a gold mine for the patient, his doctor and everyone concerned with the conduct of the hospital. It is not mixing metaphors to say that its price is above rubies. Nowhere else in the hospital can you get as compact and as comprehensive a picture of its performance as you can in the record room.

Just as the finished meal is the test of the department of nutrition, so is the finished clinical record the test of the hospital as a whole. All the ingredients of good medical service, each of the best and combined in reasonable proportions, should be found in it. Here speak the doctor, the nurse and the social worker and give a final accounting of their stewardship to those who are in authority and willing to "look at the record." Errors of omission and errors of commission are quickly revealed in this vital document and facts are here stored up for use at favorable moments in the future of the hospital.

The law recognizes the value of the medical record in medico-legal situations and leans heavily on it in disputes involving accusations of malpractice. Here is a case where moral recognition in the hospital may fall behind legal recognition in the courts. It is no exaggeration to say that failure on the part of hospital authorities to demand a good medical record, and to apply its lessons, is a disservice of the first magnitude to the patients of the hospital. It is the acid test of trusteeship and the sooner we accept this yardstick of hospital service for what it is worth, the better for our patients.

Policies, rules and regulations may be subject to change by hospital authority or by the worker, in the presence of agonizing signs and symptoms in a patient, but no item in any code of conduct is as inflexible as the one which prevails in the medical record room of a hospital. There are no exceptions to the rule in this location, and no excuse is valid which neglects to render a scientific account where the sick are concerned.

### Watch for Danger Signal

Any irregularity, omission or superficial offhand dealing with the subject leaves the author open to severe criticism and promptly puts him on the defensive. "Lack of time" by medical men for this essential activity should be regarded by the trustee as a danger signal and dealt with on the highest level of hospital statesmanship. Short of a full postmortem examination in a fatal case, there is no better check than the medical record in judging the quality of medical care in a hospital.

It is because we hesitate to look a gift horse in the mouth that the trustee, through his executive hospital officer, shies away from an inspection of medical records when he is dealing with a volunteer visiting staff. The problem seldom arises in hospitals employing full-time medical officers to care for their patients, who at the same time serve the interests of medical education and research.

Every teacher and investigator is careful in the presence of his students and his readers. The record is a source for study and investigation.

The volunteer visiting physician is naturally preoccupied with his private practice and has a limited amount of time to devote to his hospital patients. In such a case we must expect certain consequences, among which are a highly selective but disproportionate emphasis on the more dramatic and therapeutically amenable cases to the exclusion of others that may in the long run be of a more challenging nature, and neglect of the medical record which is something of a clerical chore to the busy physician.

Whatever the causes of the failure to make an adequate medical record, they must be removed and, in the process of removal, the hospital is the gainer. Physicians should be required by inflexible hospital law to write, or cause to be written, a logical and legible statement, in accordance with the principles of science, of every clinical problem that may be assigned to them.

If the doctor is treated by the trustee as a man of science rather than as a practitioner, and if he is given the tools with which to develop his talents and pursue his mission in the hospital, he will respond to this vital requirement. A hospital in which the medical men are willing and able to share their knowledge—a teaching hospital in the broadest sense of the term—and one in which they are willing and able to view their clinical material critically—a research hospital in the broadest sense of the term—is the one in which you will be most likely to find adequate records.

Strictly speaking, every hospital belongs potentially in both of these categories. In any case, every hospital prides itself on the fact that it possesses the best medical talent in the community. How then does it happen that it so often fails to meet this specific requirement in its medical record room?

The answer lies mostly in prevailing policies of medical organization in hospitals. This may, in turn, be traced to superficial trustee interest which sees more value in hospital economics, because it is more obvious and more compelling, than in solid scientific accomplishment. Perhaps the standardizing bodies tend to underestimate this criterion of hospital service and reduce the emphasis correspondingly.

The remedies are at hand. The trustee cannot be released from the need of implementing the medical record in all cases. He must therefore plan broadly for its preparation and completion and then use this priceless document as a basis for judging men when he has any prizes to distribute.

## Question of the Month

**Each month in this column one question bearing upon hospital trusteeship is presented and answered. The editor is glad to receive questions which any hospital trustee may submit. All identification will be withheld. Replies will be made by mail pending their publication.**

QUESTION: In planning for the future the question has arisen as to whether living accommodations should be provided for the hospital superintendent either within or without the institution. We would like to know what the thinking is on this subject at the present time.—R.D.L.

ANSWER: It was the custom of hospitals in the past to provide living accommodations under their roofs for the superintendents, as well as for certain other department heads and employes.

With new concepts of hospital management came a realization of the inefficiencies in housing and maintaining not only the superintendent but other employes as well. Consequently, today we see a definite trend away from providing accommodations for the superintendent under the hospital roof and toward paying that individual a sufficient salary to live elsewhere in a manner befitting the executive officer of an important community service.

It sometimes happens that the hospital property includes a home or dwelling which may be adapted to the use of the superintendent. When this is the case it is advantageous for all concerned, particularly during these days of housing shortage. Such arrangement is to the advantage of the hospital in having its chief executive close at hand at all times yet not occupying space within its four walls that might better be used for patient care. From the standpoint of the superintendent such a plan is ideal in that it eliminates the need of traveling to and from work yet affords the privacy and normal living that he deserves and needs.

Consequently, the answer would seem to be: provide accommodations for the superintendent elsewhere than under the hospital roof, if possible. If suitable facilities are available elsewhere on the property, all well and good. Salary schedules should be sufficiently flexible to consider complete maintenance, partial maintenance or no maintenance whatsoever.

## VOLUNTEER ACTIVITIES

### Let's Remember the Mr. Rohns

Mrs. Albert Rohn of Miami Beach, Fla., has given more than 4000 volunteer hours to St. Francis Hospital but she must share the credit for that achievement with her husband who during that time has cooked all the meals at home, washed the dishes and cleaned the house, thus permitting his wife to hang up such a record. There should be an honor roll for the Mr. Rohns of the nation.

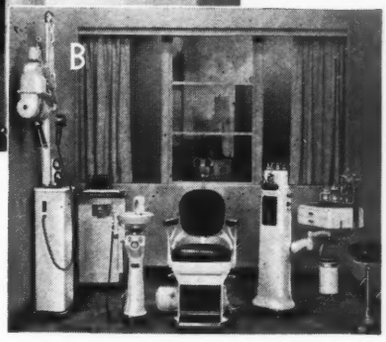
### What Volunteers Give

Volunteer service is partly giving and partly receiving. The advisory committee on volunteer service of Community Chests and Councils, Inc., New York City, makes this plain in a statement of principles on volunteer service recently drawn up.

On the volunteer's side of the fence, her responsibilities are four, according to these principles.

1. To give substantial and definite blocks of time, sincere interest, intelligence, energy and a businesslike approach to the work assigned.
2. To know the community strengths and weaknesses of the volunteer program, its objectives, problems, needs and resources.
3. To prepare adequately for the work, to adapt special skills to the required activities and to accept change of assignment when, after objective evaluation, such a change is deemed advisable.
4. To show a capacity for growth and leadership which will determine the value of volunteer service to giver and receiver.

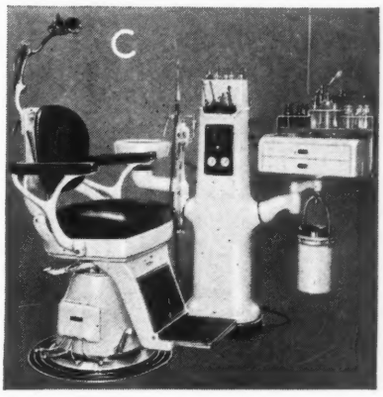
On the receiving end are the hospitals. Their responsibilities are listed on page 8 of this issue.

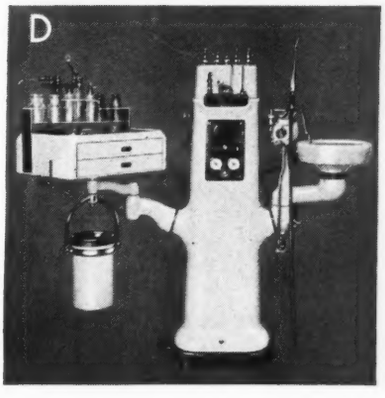




# Which Ritter ENT Unit Fits Your Hospital Needs?

There are four types of Ritter ENT Units. The Ritter Unit illustrated above has the unit on the left of the chair and the Surgical Cuspidor on the right. Just the opposite arrangement is shown in photograph B. Most users of Ritter ENT Units prefer the complete unit—with swinging cuspidor. This model is also made for positioning at either the right (C) or left (D) of the chair.

Whichever models you select, your specialists will find new operating ease with the Unit's fine precision instruments. Give their skill the advantage of this modern time-saving equipment. *Ritter Co., Inc., Ritter Park, Rochester 3, N. Y.*




FOR ADVANCED EQUIPMENT LOOK TO **Ritter**

Requests for laboratory procedures increased noticeably when the hospital engaged the services of a pathologist as laboratory director.

# Problems in Pathology

## *can be met in the small hospital*

**KURT E. LANDÉ, M.D.**
Pathologist and
Director of Laboratories
Mercy Hospital, Hamilton, Ohio*

**CHARLES J. COTTER**
Superintendent
Washington County Hospital
Hagerstown, Md.

ABOUT seven years ago Washington County Hospital, Hagerstown, Md., decided to engage the services of a full-time pathologist as director of its laboratory.

This step, contemplated ever since enlargement and renovation of the institution had increased the load of patients, had become necessary because a satisfactory clinical pathological department is one of the essential requirements for approval of a hospital by the American College of Surgeons. Thus, under a new superintendent, the hospital administration and the medical staff agreed to embark on the venture that will be described in the following paragraphs.

At the time when the pathologist started his work two laboratory technicians took care of the routine laboratory procedures for an average census of 92 patients. Since Washington County Hospital is open to all physicians of good standing engaged in practice in the county, there are no chiefs of services nor does there exist any special routine for emergencies.

Therefore, the application of laboratory tests, besides total blood count and urine examination on admission of the patient, depends entirely on the personal attitude of the attending physician. It was originally anticipated by the administration that the pathologist eventually could replace one of the technicians. But it shortly became obvious that this idea would not work out well.

The number of laboratory procedures requested by the staff members increased rather fast the moment interpretation of results, suggestions as to new methods and consultation with the pathologist got under way. Soon an additional technician had to be employed.

During 1944, with an average census of 160 patients, three technicians were fully occupied with the various requests for laboratory procedures. Electrocardiograms, basal metabolism tests and skin testing were not included among the duties of the technicians; nor did they participate in any x-ray work.

As to the thorny problem of providing the necessary number of technicians, training of suitable personnel in the laboratory turned out to be the most satisfactory solution. Several girls who had the college credits required by the technician's registry preferred to undergo practical technological training in their home town. If they lived up to expectations they were employed as junior technicians after six months. They advanced financially after they had passed their registry examination.

The histological examination of surgical material had been handled, previous to the pathologist's employment, on a purely arbitrary selective basis. Only those specimens about which the surgeon held some doubt as to the diagnosis had been sent to Baltimore for microscopic investigation. When, in accordance with the requirements of the American College of Surgeons, the microscopic examination of every tissue, except tonsils, removed by surgical intervention in the hospital became obligatory, things went on smoothly as long as no charge was made for this additional service.

However, the moment the patient was billed, considerable opposition on the part of the staff members arose against a measure whose introduction they themselves had not only approved but requested. A com-

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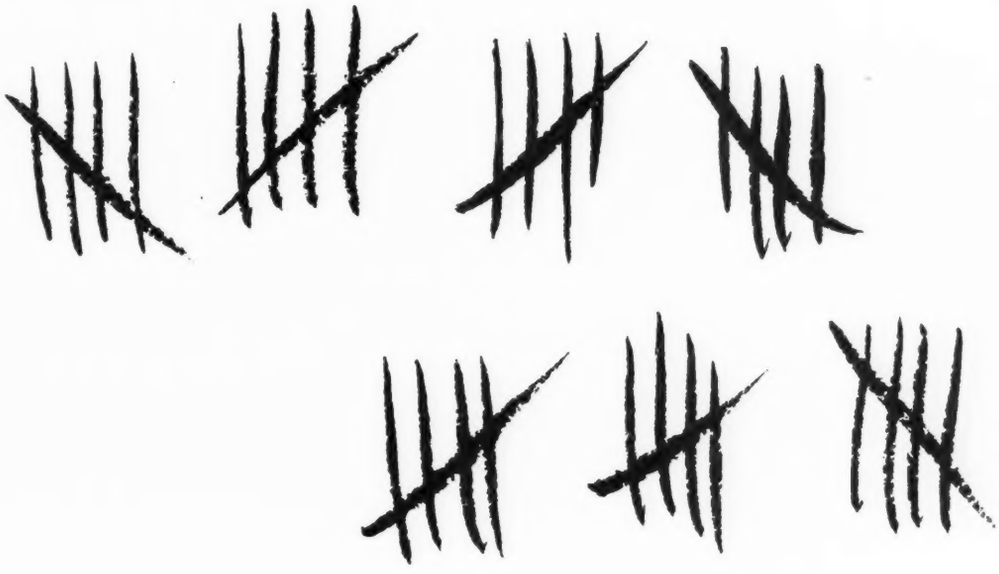
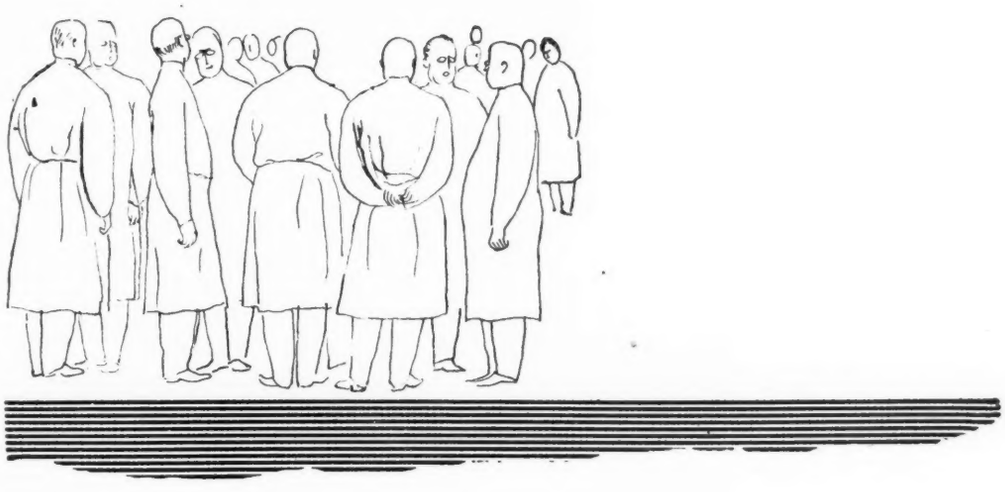
# *35 years among the first*





In 1910, an assemblage of experts ranked ether first among the ten most important drugs. In 1945, a similar compilation shows ether still crowding even penicillin, the sulfonamides, and anti-malarials for top rank. Thus after 35 years, ether retains a place among medicine's most important agents.

For more than 87 years, surgeons all over the world have depended on Squibb Ether, confident of its purity, uniformity and efficacy.

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

promise solution which increased the fee for use of the operating rooms and included the price for tissue examination finally took care of the situation.

Not only did the question of adequate laboratory charges arise when surgical pathological specimens were involved but, whenever a patient needed many of the diversified laboratory tests in order to establish a diagnosis or to control a therapy, the laboratory bill was subject to criticism and argument. Newly introduced laboratory methods, especially desired by some physicians, often lost much of their initial popularity with the respective doctors once expenses accrued for them.

### Price Limit Set at $25

In the long run, the best way out of this dilemma, for hospital, patient, hospital care corporation and attending physician alike, proved to be an upper price limit for laboratory work at a level of $25 a patient. Thus, a certain balance was struck between cases needing few or a moderate number of tests beyond routine blood count and urine examination and those needing many.

As to the relations between the director of laboratories and the staff members, much depends upon the former's tact, discretion and ability to get along with people. Especially in a smaller community, it takes time for the members of the medical profession to get accustomed to the fact that they have at their (free) disposal a physician who specializes in clinical pathology or laboratory medicine. There can be no doubt that the greater part of the staff learns to profit by the expert interpretation of diagnostic laboratory tests through the clinical pathologist.

The mutual respect between the practitioners of medicine and the various specialists will automatically lead to cordial relations and to benefit for the patients. The laboratory physician is not a competitor of the practitioner so that contact with the latter's patients is free of the real or imaginary danger of alienation.

One of the shortcomings of Washington County Hospital to which the American College of Surgeons took exception was the absence of a satisfactory necropsy service. Shortly after the pathologist had arrived the funeral directors of the county were invited to a meeting by the hospital superintendent. At this occasion the functions of the newly appointed director of laboratories were explained to them. The need for and interest in postmortem examinations on the part of the institution and the physicians and their value to the surviving relatives of the patients were stressed and the undertakers were asked for their cooperation.

On the whole, with a few sporadic exceptions, this goal was reached, so much so that in several instances permits for postmortem examinations could be obtained through the helpful interference of the funeral director. This friendly and cooperative attitude could be gained by making several concessions: restraint in the employment of over-long body incisions; sparing of the neck region except in medico-legal necropsies; incisions below the nipples; careful tieing of the large vessels and, above all, immediate performance of the postmortem examinations once the permit had been obtained.

In an open hospital without any resident house officer the all too often thankless task of procuring permits for postmorten examinations devolves mostly upon the pathologist. If the latter has had some contacts, personal or otherwise, at least through having met the family of the deceased when laboratory tests were made for the patient, it is easier to rally a reluctant family group to a consent. But, if one is forced to deal with total strangers, the odds are sharply against a success.

It is impossible to predict the mental reactions of individuals to the different arguments in favor of necropsies. Education, social status, religious beliefs and other imponderabilia make any prognosis as to whether one will succeed in obtaining a permit mere guesswork. This represents one more and quite weighty reason that an attempt to obtain permits should be made in every instance of a hospital death.

As to the often heard objection, from physicians as well as relatives of the patients, that the case in question was diagnostically sufficiently clear, every pathologist knows from abundant experience that the most obvious and seemingly uninteresting case may turn out to be a veritable mine of unexpected pathological findings.

From a scientific point of view the postmortem material at Washington County Hospital (an average of from 80 to 85 necropsies a year) was variegated and interesting enough to form the basis of several publications.[1,2,3,4,5,6] Every facility existed to work up the cases and to investigate them from every angle. The same, naturally, holds true for the surgical biopsies. The specimens, gross and microscopic as the case might be, were demonstrated in one monthly clinical-pathological conference.

For the other meetings the pathologist's advice was usually sought as to what kind of patients admitted to the hospital would lend themselves to clinical demonstrations because of their special diagnostic or therapeutic interest for the staff members. The director of laboratories was, as a rule, expected to contribute to the discussion of the various topics from his special point of view. These conferences turned out to be stimulating and instructive. Occasionally, outside speakers were invited to treat some particular subject in a more academic form.

### Pathologist as Teacher

As far as teaching was concerned, the hospital pathologist was expected to devote a large share of his time and energy to the school of nurses. The courses in anatomy and physiology, in pathology and microbiology and part of the curriculum in medicine had gradually to be taken over by him. From September to May this meant one or two hours of teaching a day, not counting grading of papers and preparation of tests.

Such an extensive teaching program for the pathologist may furnish some compensation in the contacts with a group of young people eager to learn. However, after a year or two a certain monotony prevails, as the limitations of the curriculum of

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[1] Landé, K. E., and Wells, S. R.: Experiences Under the Medical Examiner's System. J.A.M.A. **125:**897-900 (July 29) 1944.

[2] Landé, K. E., and Wolff, G.: Frequency of Tuberculous Lesions at Autopsy. Some Epidemiological Inferences. Am. Rev. Tuberc. **44:**223. 1945.

[3] Landé, K. E., and Wolff, G.: Same Title. Second communication. Am. Rev. Tuberc. **51:**231. 1945.

[4] Landé, K. E.: Unusual Manifestations and Pathology of Congenital Syphilis. Am. J. Clin. Path. **10:**736-750. 1940.

[5] Landé, K. E.: Diabetes Mellitus in a Cat. Am. J. Clin. Path. **14:**590. 1944.

[6] An Outstanding Report. (Annual Report of the Washington County Hospital. Hagerstown, Md., by C. J. Cotter.) Hosps. **19:**89-90 (August) 1945.

necessity forbid any exhaustive treatment of the subject matter.

On the other hand, it would be unfair to look at the situation only from this angle. The hospital whose smooth functioning depends upon the presence of an up-to-date school of nurses has to provide for a satisfactory teaching staff. Naturally, it falls back on the man who is available. Part of the clinical pathologist's salary, in fact, was paid in recognition of his teaching activities.

In retrospect, though, it would appear more advantageous for all concerned if part of the subjects mentioned could be taught by an instructor who has specialized in nurses' training and not by a specialized physician.

### How Shall He Be Paid?

There remains the problem of remuneration. Is a small to medium-sized hospital financially in the position to employ a well-trained specialist in clinical pathology and to pay him an adequate salary? It has to be mentioned here that when the hospital laboratory is the only one in the whole county (perhaps with the exception of a state or county branch laboratory) few opportunities for outside income exist for the director of laboratories if he is employed on a straight salary basis.

If the minimum rates proposed in a recent circular of the American Society of Clinical Pathologists were to be followed, then only a younger man, just out of training, could be retained. But, for him the absence of any expert advice and consultation, the lack of constant intercourse with other representatives in his field and the necessity to make, from a scientific point of view, the most of relatively limited clinical, surgical and necropsy material represent considerable handicaps.

Also, the amount of work to be accomplished in a small to medium-sized institution, even including an extensive teaching program in the school of nursing, may not satisfy the ambition and energies of a young physician ready to apply his knowledge. Thus, the solution, which has been tried out in many localities with great success and satisfaction to both pathologist and hospital, would be to have one man take care of several hospital laboratories. He can easily divide his time among several small and medium-sized institutions, residing in the most centrally located town in the area.

Such an arrangement was anticipated, on merely geographical consideration, in Hagerstown. But local prejudices, state borders and other reasons always interfered. However, if the small and medium-sized hospitals of this country are expected to have at their disposal a laboratory and pathological service of high standards, the only way they will be able to achieve this goal is to pool the resources of several institutions. Only under such an organization will it be possible to utilize best the relatively limited number of specialists in the field of clinical pathology. In no other way will the small and medium-sized hospitals be able to play to the fullest their highly important rôle in the health program of the nation. In this fashion alone will they be able to participate in the expansion of training facilities for young physicians in internships and residencies and in the retraining of veterans. Last but not least, only such a plan will provide for the best possible medical care of their patients.

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# A Study of Streptomycin

**FRED W. ELLIS**
Department of Pharmacology
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ALTHOUGH antibiotic activity has been known for many years, only comparatively recently have substances possessing this property become of practical chemotherapeutic value. Since penicillin has been shown to exert a powerful antibacterial effect, the search has been intensified to uncover other, perhaps more useful, agents. Practically every group of living organisms has been found to produce some kind of antibiotic substance.

One of the most recent agents of this nature which promises to have wide therapeutic application is streptomycin. Streptomycin is produced by the group of actinomycetes called Streptomyces and was first described in January 1944 by Waksman and his workers at the New Jersey Agricultural Experiment Station at Rutgers University.

Most of the antibiotic substances known before the discovery of streptomycin, including penicillin, act primarily on gram-positive organisms. However, streptothricin is effective against certain gram-negative organisms and penicillin is highly effective against the gram-negative Neisseria group of bacteria.

Early work with streptomycin showed that this antibiotic possessed marked *in vitro* antibacterial effect. Many organisms, including the gram-negative intestinal bacteria and even the tubercle bacillus, as well as certain other bacteria against which penicillin is not effective, were shown to be susceptible to streptomycin.

*In vivo* investigations likewise demonstrated the ability of streptomycin to offer marked protection against experimental infections which hitherto were uncontrollable by chemotherapeutic agents. Because penicillin is definitely restricted in the range of its antibacterial activities, considerable clinical interest is being focused on this new antibiotic, streptomycin.

**Pharmacology.** The complete pharmacological picture of streptomycin is not available at the present time owing to a lack of the substance for experimental purposes. However, a few observations have been made concerning the general distribution and fate in the human body.

Clinical studies have indicated that after oral administration of from 500,000 to 1,000,000 units a day, streptomycin is not absorbed in sufficient quantities to give a significant blood level, nor do appreciable amounts appear in the urine. This substance apparently is not destroyed in the gastrointestinal tract, as is the case with penicillin, but is excreted in high concentrations in the feces.

It is obvious, therefore, that streptomycin passes through the gut wall

with difficulty and that little or no streptomycin reaches the general circulation following this method of administration. However, the oral route of administration may prove of value in treating certain local infections within the intestinal tract.

Streptomycin may be given by intravenous, intramuscular or subcutaneous administration. Sufficient absorption occurs following any of these routes to give adequate antibacterial blood levels for about three or four hours. The intramuscular route is the method of choice at present, whereas the intravenous method offers no significant advantage and, in fact, favors the likelihood of reactions.

Intrathecal administration may be used safely, and the drug may be given also by nebulization when indicated.

Following parenteral administration, streptomycin appears to have a fairly general distribution throughout most of the body fluids, including blood, bile, ascitic fluid, pleural fluid and urine. The blood level apparently is maintained slightly higher for a longer period of time than after a single dose of penicillin. Diffusion through the placenta makes the drug available to the fetal circulation. Only small amounts of streptomycin appear in the spinal fluid of healthy individuals, but in cases of meningitis the concentration in the cerebrospinal fluid increases markedly.

Like penicillin, streptomycin is excreted quite rapidly in the urine following parenteral administration. It has been estimated that from 50 to 80 per cent is excreted by the kidneys in twenty-four hours.

The commonest toxic manifestations have been correlated with an impurity in the preparation. These possible reactions include: pain at the site of injection, occasionally chills and fever, nausea, vomiting, headache, transient urticaria and fainting. No serious and irreversible reactions have been reported to date. In many instances, no toxic responses at all have been observed even upon repeated administration for a considerable period of time.

**Clinical Applications.** Experimental evidence has justified the clinical trial of streptomycin in many infections caused by organisms which are not susceptible to either penicillin or the sulfonamide drugs. Outstanding among these conditions are infections caused by colon bacilli, bacteria of the dysentery and typhoid groups and the organisms of tularemia and tuberculosis.

In an early report on the clinical use of streptomycin, Reimann observed that this drug was of great benefit in treating typhoid fever. It is recommended in his report that the drug be given both orally and parenterally in such cases. Helmholz has found the drug to be an extremely useful urinary antiseptic. After parenteral administration it is possible to clear the urine of the common organisms which cause urinary tract infections.

Based upon striking chemotherapeutic efficiency in arresting the progress of experimental tuberculosis in guinea pigs, streptomycin has been employed by Hinshaw and Feldman at the Mayo Clinic in clinical tuberculosis. From this work it is apparent that a rapidly effective curative action does not occur but that extensive and progressive pulmonary lesions of known origin show a tendency to improve promptly in a

manner similar to the natural process of healing.

These preliminary impressions indicate that streptomycin exerts a limited suppressive effect in clinical tuberculosis. However, no clear evaluation is possible at this time because of the limited number of cases studied and the long observation period required in a study of this sort.

Other conditions in which streptomycin has had preliminary clinical trial include brucellosis, infections caused by the Friedlander group, influenzal meningitis and tularemia. Observations in a few cases of early syphilis give an indication of a possible antispirochetal action.

More extensive clinical work is necessary before streptomycin can be adequately evaluated. It is fairly well established, however, that this new agent possesses remarkable activity against certain organisms, especially gram-negative bacteria, which, heretofore, have been uninhibited by drugs. An additional virtue of this antibiotic is its low toxicity. It is highly possible, therefore, that streptomycin may well prove to be as valuable as penicillin and the sulfonamides in the prophylaxis and treatment of diseases.



# CLINICAL BRIEFS

**Conducted by E. M. Bluestone, M.D.**

## Electron Microscope

John H. Jupe in the *British Medical Journal* for October 13 gives an interesting description of the electron microscope. The electron microscope was developed because some branches of scientific research were hampered by the limitations of the light microscope.

In the electron microscope there is an electron source, usually a heated cathode, corresponding to the light source of the ordinary microscope; there are also analogous electronic condensing and objective lenses. The electron stream is accelerated to extremely high speeds by the use of high voltages and it takes on the characteristics of any object placed in its path. It is then allowed to fall on a fluorescent screen where a shadow image of the object appears.

With the instrument described by the author, direct magnification can be varied in 40 steps from 100 to 20,000 times and with it the naked eye can see details as small as one fourth millionth inch. By taking photographs with this apparatus, normal photograph technic will permit final magnification of the object to more than 100,000 diameters. With the help of the electron microscope a number of viruses have been observed for the first time and the specific action of substances or bacteria has been investigated more closely.

It is more difficult to mount specimens for the electron microscope than for the older microscope because the cathode ray stream is stopped by anything thicker than about one millionth inch. The usual support is a film of nitrocellulose not exceeding this thickness and itself supported by a metal gauze disk with about 200 meshes to the inch.—JOHN F. CRANE.

## Review of Roentgen's Work

Radiology celebrated the fiftieth anniversary of Roentgen's discovery of the x-ray by devoting its November (1945) issue to a survey of the progress made by his successors, an evaluation of the present status of their acomplishments and hopeful glances into the future.

Translations of parts of Roentgen's original papers are reprinted; one is

struck again by the comparative simplicity of the work upon which this epochal communication was based:

"It is seen, therefore, that some agent is capable of penetrating black cardboard which is quite opaque to ultraviolet light, sunlight or arc-light. . . . The justification of the term 'rays,' applied to the phenomena, lies partly in the regular shadow pictures produced by the interposition of a more or less permeable body between the source and a photographic plate or fluorescent screen.

"I have observed and photographed many such shadow pictures. Thus, I have an outline of part of a door covered with lead paint; the image was produced by placing the discharge tube on one side of the door and the sensitive plate on the other. I have also a shadow of the bones of the hand; of a piece of metal where the x-rays show the want of homogeneity, and of other things."

The editorial of the *Journal of the American Medical Association* which first officially recognized the x-rays is also reprinted; its caution is remarkable: "It [Roentgen's discovery] hints at future valuable physiologic revelations as well as diagnostic aids. It is only a hint, however, and whether it is to be ever realized to any extent is perhaps open to serious question."

All the articles in this issue are of interest. The first by Glasser and the last by Cipollaro are the most "purely" historical, the former discussing Roentgen's reaction to his discovery, the latter describing the earliest Roentgen demonstration in America of a pathological lesion by Professor Frost at Dartmouth. Since then, the Roentgen ray tube has undergone many radical changes, and Coolidge and Charlton describe its development from an uncertain and feeble source of radiation into the present powerful precision tool of stability and flexibility with such ease of control that it "has come to be as easy to operate as an incandescent lamp."

Much space is, of course, devoted to the development of the Roentgen apparatus, Roentgen diagnosis and therapy in the three articles by Hodges, Rigler and Pfahler. But Roentgen's discovery led to more than the use of the x-rays themselves. Arthur Compton, for example, points out that it led to our modern knowledge of the atom and the laws of motion of stars and atoms moving at very high speed and more precise laws of gravitation; that it has improved our understanding of the nature of light and has given us such practical developments as the radio and the atomic bomb.

Significantly, however, Compton concludes by stressing the fact that the greatest human meaning of Roentgen's work lies in the increasing interdependence of people's lives with a resulting greater need for cooperation. Significant, too, is the fact that several of the other contributors have stepped outside the area that was, but a short time ago, regarded as the only one proper to them to discuss the reciprocal relations existing between the medical phases of Roentgen's discovery and the society which that discovery helped to bring into being.—SIGMUND L. FRIEDMAN, M.D.

## Fly Control With DDT

We learn from the January issue of the *Bulletin* of the U. S. Army Medical Department that the best method for treating screens with DDT is by brush application. Three different methods were tried at Camp Gordon, Georgia. Five per cent DDT was applied by: (a) painting; (b) dipping, and (c) spraying. After allowing a three day period for the formation of crystals, the treated samples were examined under the microscope. It was observed that the DDT crystalline structure formed by painting produced both larger crystals and thicker clusters of crystals.—JOHN F. CRANE.

# *Poultry* Has So Many Possibilities

**KATHRYN NILES**
Home Economics Director
Poultry and Egg National Board
Chicago

MORALE is a fine-sounding word that is freely tossed around, and everybody will attest the fact that good food is in the category of morale builders. The patient, the hospital superintendent, the student nurse and Steve, the handy man, all are interested in good meals. Everyday dinners are transformed into festive occasions when delicious chicken and plump roast turkey are served. With the current abundance of poultry, the dietitian can plan nutritious meals around the ever popular chicken and turkey and obtain whole-hearted approval, even from the kitchen contingent.

Nutrition news today spotlights protein foods. Chicken and turkey share the high protein quality of other meats. Poultry meat is a good source of several important nutrients. A relatively high content of the water-soluble vitamins, notably thiamine, riboflavin, nicotinic acid and ascorbic acid, and of available iron and phosphorus gives chicken and turkey their high rating among the "basic 7" foods.

While it is true that more pounds of chicken and turkey will be eaten because people like them than for their nutritive value, increased consumption is justified by their superior nutrition. This knowledge should enhance the pleasure with which chicken and turkey are eaten. The nutritive properties coupled with delicious flavor and appetite appeal make poultry a frequent order on hospital menus. Adaptability to the great variety of cooking methods and styles of service makes it a versatile meat.

Every effort is made by hospital dietitians to avoid monotony in menu planning, but some foods are popular enough to serve as often as twice a week or more; such a food is chicken. Added to the time-tested methods for roasting, stewing and frying, are zesty recipes for Southern barbecued chicken, Hungarian chicken paprika, smothered chicken, skillet chicken with rice from Mexico and other round-the-world favorites. Frying sized chickens and fowl (stewing hens) are most plentiful now and lend themselves ideally to these dishes.

A little skill and ingenuity transform leftover chicken and turkey into the second-day treats. Chicken shortcake, made with creamed cubed chicken baked under a topping of biscuit dough or cornmeal muffin mix, is a new and delicious variation. Chicken strata, using as a foundation stale bread squares and a custard-thickened chicken-in-cream sauce poured over the bread then baked, is an easy supper dish.

Ground chicken-burgers with a rasher of bacon will delight the student nurses. Incidentally, chicken-burgers are an ideal way to use gizzard, heart and neck meat. Or try minced chicken livers folded in thinly rolled biscuit dough and fried in deep fat. Chicken timbales or croquettes are proved popular menu hits. Escalloped chicken and noodles has a stick-to-the-ribs quality, both filling and economical as a luncheon entrée. Salads or sandwich fillings made with chicken are on the de luxe list; a tasty combination is chicken and avocado salad.

Roast turkey is an American tradition formerly associated with special holidays. The turkey industry has demonstrated the year-round popularity of the big regal bird and has made its purchase possible any month of the year. Currently, the large turkey is especially abundant and should be attractive to the menu planner. Remember there are other

Fried chicken livers, broiled tomato on English muffin, bacon strips.

**Skillet chicken with rice and slices of onion is a Mexican favorite.**

methods than roasting to prepare and serve turkey.

Turkey, disjointed and cut up into pieces, can be stewed until tender, then served as turkey pie, in casserole dishes, salads, croquettes and hash. Turkey chowder is a good suggestion for a chilly spring evening. With the return of G. I. Joe from India and other points East, a liking for curried chicken or turkey may have developed. Be prepared to satisfy such requests.

When the dietitian exercises skill and caution in selection, storage, care and cookery, plans for the thrifty and satisfying ways of utilizing poultry are not negated. Correct selection is the first step to delicious chicken or turkey dinners. The style of service and the number to be served determine the kind of bird and the amount to be purchased.

Chicken and turkey are available in these market styles:

1. New York or Market Dressed: Head and feet on, plucked but not drawn. In turkeys, it is important to have the butcher remove the leg tendons before he cuts off the legs. Tendons become hard and dry during roasting, making drumstick meat less desirable and hard to slice.

2. Drawn: Usually fresh drawn; generally requires removal of lungs, kidneys, oil sac and pin feathers before cooking.

3. Eviscerated: Full drawn and ready to cook; quick-frozen, requiring only defrosting before cooking. Institutional packages are labeled and marked with distributor's name; available as broilers, fryers (whole, quartered or disjointed) and roasters.

4. Cut-Up: Chickens are disjointed into legs, breast, wings, back, neck and giblets; gizzard and heart are usually sold together and livers separately. Frying size (2½ to 3½ pounds) is usually used. This type allows the purchase of any part of the chicken in any desired amount. Turkeys are sold in halves (split lengthwise) or in individual pieces (legs, breasts, backs, wings, necks and giblets) and are available in some markets.

When purchasing fresh chicken and turkey, look for these quality marks:

1. Clean, waxy skin with few pin feathers and no bruises or discolorations.

2. Well-fleshed breast and legs; in a turkey, a short body and broad breast indicate a meaty bird.

3. Streaks of fat underneath the skin on breast, legs, thighs and back, the quantity increasing with the size and age of the bird.

4. Flexible-tipped breastbone and tender soft-meated but firm muscles indicate a young bird.

The cost per pound of edible meat is just about the same for New York dressed poultry and eviscerated poultry. Perhaps in some cases a slight premium is paid for the extra service. Institutions need to weigh their costs of time and labor in deciding the style of poultry best suited to their needs. Buying a pound of meat per person New York dressed weight allows enough for two helpings each at the first meal and choice tidbits for a second meal. For broiled chicken, plan ¼ to ½ bird per person.

To defrost birds, if frozen poultry is used, choose one of these methods, depending on size, style and time available:

1. Place packaged chicken or turkey (or take out of package) on refrigerator shelf overnight.

2. Leave packages at room temperature for several hours, possibly up to six hours.

3. Place poultry in cold water until pliable, about three hours.

To hasten defrosting of cut-up poultry, separate pieces when pliable enough. A defrosted chicken may be held in the refrigerator at 40° F. up to two days. Complete defrosting before cooking is preferable but if the chicken is cooked before it is completely defrosted, allow more time in cooking. Do not attempt to hurry the cooking by using high temperatures.

In the preparation of birds freshly drawn and plucked clean of all pin feathers, wash the outside well, rubbing with cloth or soft brush. Remove any bits of lung and kidney remaining in the cavity. Cut out the oil sac. Rinse with cold water and blot dry with a clean towel. Refrigerate at 40° F. until birds are stuffed.

All too often, cases of food poisoning in hospitals and other institutions receive unwelcome publicity. To prevent the common type of food poisoning, the proper care of perishable food is highly important. *Chicken and turkey, whether uncooked or cooked, should not remain in the incubation zone of 50° F. to 130° F. for more than four hours.* Frozen eviscerated chicken may be kept an indefinite length of time in the freezing unit, but once defrosted, wrap loosely in waxed paper and refrigerate; do not hold longer than two days at 40° F. or less. Chickens and turkeys that are New York dressed should be drawn immediately and promptly refrigerated, loosely wrapped in waxed paper at a

temperature not higher than 40° F.; do not hold them longer than two or three days.

When whole birds are to be cut up, cut them up just before cooking. Refrigerate cooked poultry meat promptly after the meal. Cover well to prevent drying out and the absorption of odors from other foods. Even though it has been refrigerated, use cooked chicken within three days. With this care, dietitians will have no worry over doubtful chicken salad.

### Use Care With Dressing, Gravy

Further care in the prevention of food poisoning is needed in the handling of dressing and gravy. If stale bread is not available, dry fresh bread in wire baskets so it will not mold. Use either *freshly made* soup stock or stock that has been kept under refrigeration at 40° F. no longer than three days. Taste the stock before using. It is preferable to use the dressing mixture immediately but, if necessary, make the dressing no more than twelve hours, or overnight, before using it and refrigerate it promptly at a temperature below 40° F. Never stuff a bird and hold it out of refrigeration more than two to three hours before roasting. Refrigerate cooked dressing in a covered dish promptly after the meal and use it within two days.

In making gravy, use fresh stock, if at all possible. Since soup stock spoils at temperatures above 40° F. in less than forty-eight hours, cool the stock rapidly to 50° F., refrigerate it at from 33° to 38° F. and do not hold it longer than three days. Gravy requires the same refrigerator care as stock.

Some retail markets today sell giblets—hearts, livers and gizzards together—or livers alone by the pound. Frequently, in hospitals, the giblets are used in gravies, soups or hash and are not fully appreciated. Yet giblets, especially the livers, offer rich value in iron and vitamins. Giblets have many possibilities for delicious main dishes. An excellent way to entice flagging appetites is a dish made of braised giblets and mushrooms, served with crisp bacon on toast points. Gizzards and hearts require moist heat at simmering temperatures to make them tender.

Whatever the style of service, cook the giblets until tender in seasoned water first. Cook the tender livers for a brief period only. In the care of giblets, remember that the gizzard, heart and especially the liver spoil quickly and should be cooked promptly after being cleaned and washed. Cutting up the giblets hastens the cooking period and also eliminates their identity, which is important to some tastes for esthetic appeal.

Chicken and turkey should always be cooked well done. Cooked to "fork tenderness" with the appearance of almost falling away from the bones, chicken and turkey meat will not have that pink, stringy look sometimes found in large quantity cookery of poultry. The secret of poultry cookery is low to moderate temperature. Like any other protein, high temperatures toughen poultry proteins and dry the meat.

Regardless of the age and size of the bird, a low temperature cooks the chicken or turkey uniformly tender, helps to keep the juices in the meat and reduces shrinkage, giving more servings per pound. The happy results are attractive, flavorful dishes welcomed by all.

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# Soft Diets Made Appetizing

**BERTHA M. SMYERS**

Dietitian, Hillcrest Memorial Hospital, Tulsa, Okla.

SINCE World War I our knowledge of nutrition has advanced tremendously. The dietitian has attained more recognition and is in a position to stress the importance of proper food and food habits. The physician is well aware of the value of balanced, adequate diets and is finding them a useful tool, not only in therapeutic but also in "constructive" medicine. The science of nutrition is now a part of medical discipline and is coming into its own.

Failure to meet the nutritional requirements may have any of the following results: faulty digestion or absorption in the blood stream, abnormality of the gastrointestinal tract, failure to utilize essential nutrients after they have reached the blood stream. A patient's nutritional status today depends on the events of all past days. Therapeutic diets all too frequently have been planned shortsightedly, without regard to the needs of the individual.

A physician may or may not prescribe a dietary routine, but it is the dietitian who is ultimately responsible for the patient's diet. Adequate meals may be planned, but if they do not appeal to the patient from the standpoints of palatability, attractiveness, size of servings or consistency they have little effectiveness. The planning of the diet is an art as well as a science.

The term "soft diet" would indicate a diet that is soft in texture, consisting of liquids and semisolid foods. It is an intermediate step between the light and the liquid diets. It is low in residue and is readily digested. No spice or condiments are used in the preparation. The diet is restricted since only puréed vegetables are served. Meat is limited and seldom used.

### Need Proteins of High Quality

Ideally, the undernourished patient who needs protein food stuffs should have the highest quality proteins as represented by concentrated meat broths, milk, eggs, cheese and fish. In serving cereals in the soft diet the one big problem is to find a way to supplement or improve the protein efficiency of these foods. The soft diet should be adequate, containing foods moderately low in cellulose and connective tissue. It is nonstimulating and should contain approximately 65 grams of protein, 80 grams of fat, 225 grams of carbohydrates and 1900 calories.

Such a diet should include eggs (not fried), cottage cheese, cereal,

refined macaroni, spaghetti, white bread toasted, white crackers, puréed vegetables, potatoes (not fried), fruit cooked without skin, purée of ripe bananas, plain desserts, such as puddings and gelatin, and frozen desserts that are made from refined fruits.

Most foods can be so disguised that they will be pleasing to the eye, appetizing and nutritious. The accompanying recipes illustrate this point.

**Molasses Eggnog**

1 cup whole milk
4 tablespoons dark molasses
1 whole egg

Place ingredients in malt mixer and let run for five minutes. Serve cold.

**Health Drink**

1 medium fresh raw beet (liquidized)
1 cup pineapple juice
½ cup coffee cream

Mix the beet and pineapple well, add cream and ice. Serve at once.

**Health Ice Cream**

1 quart coffee cream
2 whole eggs
1 teaspoon vanilla
½ cup sugar
1 cup grapenuts
½ cup pecan meats finely chopped (if patient can tolerate them)
¾ cup ground raw liver
1 teaspoon red fruit coloring

Beat eggs until creamy, add sugar, vanilla, and the red fruit coloring. Mix well, add cream and freeze until mixture begins to thicken; add ground liver, grapenuts and pecan meats and continue freezing until solid. Fill freezer three fourths full to start as the liver, grapenuts and expansion during freezing require space. Pack freezer one hour, using four parts ice to one of salt.

The patient who is seriously ill must have special care and food to maintain his nutritional balance because when the body is completely at rest and without the stimulating influence of food the production of energy is reduced to its lowest level.

The modification of the diet to meet a specific pathological condition is one of the most important aspects of diet therapy. The object of the dietary treatment is to depress the excess flow of acid and to prevent any irritation. Fat should be given in the form of cream and protein, in the form of milk and eggs. Bulk food should be given in small amounts at frequent intervals to avoid pressure on the stomach walls. No food should be given that is extreme in temperature.

## FOOD FOR THOUGHT

The new 80 per cent extraction flour will be enriched to the levels required in War Food Order 1, the U. S. Department of Agriculture has announced. Therefore, it behooves hospitals to buy enriched flour or to enrich it themselves.

As milled and before enrichment, the new flour will have a higher content of iron, B vitamins, especially thiamine, and a better quality of protein than the present unenriched white flour which some hospitals are still using.

The new 80 per cent flour makes excellent toast. Most cakes baked with it will have much the same characteristics, the American Institute of Baking reports following experiments.

Southern institutions that serve much of their bread in the form of biscuits or hot bread will find difficulty in baking these from 80 per cent flour, it is declared.

Great Britain is now grinding its flour to 85 per cent extraction and France, to 90 per cent. One advantage of our new 80 per cent flour is its slightly greater protein content.


# Sunway BEVERAGE BASE

## fortified with Vitamin $B_1$ and C

## available in Orange, Lemon and Lime Flavors

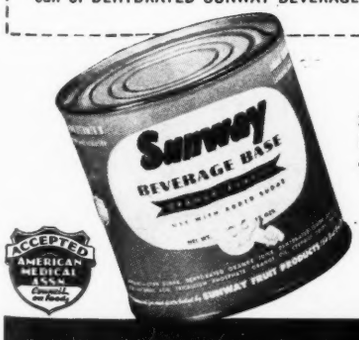
### 12-Oz. Can Makes 4 Gallons of Beverage

This can when packed contained 7.69 GMS. of VITAMIN C (Ascorbic Acid) and .0649 GMS. VITAMIN $B_1$ (Thiamine Hydrochloride).

The FINISHED BEVERAGE, made according to directions on label, will contain 120 MGS. VITAMIN C, 1.0 MG. of VITAMIN $B_1$ and 116.3 CALORIES, TO EACH 8-OZ. GLASS.

This provides 100 and 400 per cent respectively of the adult minimum daily requirements for VITAMINS $B_1$ and C.

19 OUNCES of FRESH NATURAL, tree-ripened FRUIT JUICE was used in the making of this 12-ounce can of DEHYDRATED SUNWAY BEVERAGE BASE.




Sunway Beverage Base makes it possible to supply nutritious beverage juices at a moment's notice in hospitals, institutions, etc. A beverage base that furnishes high nutritional values of citrus juices and of ascorbic acid and thiamine hydrochloride . . . at a minimum of expense.

These delicious new dehydrated fruit juice flavors are developed by a new and exclusive process and are ***Easy to Prepare*** — just add water and sweeten.

**So Economical to Use**—One 12-ounce can of SUNWAY BEVERAGE BASE makes 4-gallons of true fruit beverage, and costs only $1.50. Cost of 8-oz. glass of "Sunway", including sugar is approximately 2½ cents.

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If you have not tried SUNWAY BEVERAGE BASE, send for details today.

Sunway Beverage Base has been accepted by the Council on Foods and Nutrition of the American Medical Association.

## SUNWAY Fruit Products

CHICAGO 11, ILLINOIS

# Menus for April 1946

Phyllis C. Toevs
Coffey Memorial Hospital
Portland, Ore.

### 1
Half Grapefruit
Scrambled Eggs, Toast
•
Julienne Soup
Chicken à la King
Baked Squash
Mashed Potatoes
Lettuce Salad
Rice Custard
•
Boston Baked Beans
With Bacon Strips
Brown Bread
Perfection Salad
Rhubarb Sauce

### 2
Pineapple Juice
French Toast, Maple Sirup
•
Vegetable Soup
Liver and Country Gravy
Mashed Potatoes
Braised Celery
Sliced Tomato Salad
Fruit Cup
•
Cheese Rabbit
Potato Cakes
Green Salad
Lemon Chiffon Pudding

### 3
Stewed Prunes
Soft Boiled Eggs, Bacon
•
Cream of Potato Soup
Veal Fricassee
Baked Potatoes
Asparagus Tips
Pear-Nut Salad
Cottage Pudding
•
Macaroni and Cheese
Harvard Beets
Carrot and Raisin Salad
Hard Rolls
Frozen Strawberries

### 4
Orange Juice
Sausage Links
•
Bouillon
Baked Beef Tenderloin
Potatoes au Gratin
Stewed Tomatoes
Peach Cobbler
•
Meat Loaf
Escalloped Corn
Lettuce With 1000 Island
Dressing
Gelatin, Sugar Cookies

### 5
Bananas
Shirred Eggs
•
Cream of Tomato Soup
Baked Salmon
Creamed Potatoes
Buttered New Peas
Cabbage Salad
Apple Pie
•
Eggs à la Goldenrod
String Beans
Tomato Aspic Salad
Italian Plums

### 6
Kadota Figs
Bacon Strips
•
Corn Chowder
Roast Pork
Mashed Potatoes
Diced Carrots
Molded Vegetable Salad
Baked Apples
•
Spanish Rice
Fresh Spinach With Lemon
Avocado Salad With
Grapefruit
Baked Custard

### 7
Grapefruit
Shirred Eggs, Bacon
•
Cream of Spinach Soup
Roast Chicken With
Dressing
Candied Sweet Potatoes
Peas
Celery and Olives
Ice Cream
•
Baked Potatoes
Creamed Carrots
Cottage Cheese and
Pineapple Salad
Frozen Berries
Cake

### 8
Orange Juice
Soft Boiled Eggs
•
Onion Soup
Broiled Lamb Chops
Mashed Potatoes
Buttered Cauliflower
Deviled Egg Salad
Berry Pie
•
Chicken Salad
French Fried Potatoes
Assorted Relishes
Chocolate Pudding

### 9
Applesauce
Scrambled Eggs
•
Tomato Bouillon
Creamed Tuna on Toast
Baked Potatoes
Fresh Wax Beans
Chef's Salad
Fruit Gelatin
•
Sandwiches
Potato Chips
Spring Salad
Old-Fashioned Peaches

### 10
Stewed Prunes
Poached Eggs on Whole
Wheat Toast
•
Vegetable Soup
Roast Veal
Browned Potatoes
Julienne Carrots
Apple and Celery Salad
Strawberry Ice Cream
•
Creamed Eggs and
Mushrooms
Buttered Asparagus Tips
Fruit Gelatin Salad
Chocolate Cake

### 11
Sliced Bananas
Bacon Strips, Toast
•
Alphabet Broth
Corned Beef
Boiled Potatoes
Boiled New Cabbage
Combination Fruit Salad
Snow Pudding
•
Chop Suey With Rice
Beet Salad
Stewed Rhubarb
Sugar Cookies

### 12
Tangerines
Soft Boiled Eggs
•
Cream of Corn Soup
Fried Halibut
Escalloped Potatoes
Mashed Rutabagas
Green Salad
Lemon Pie
•
Omelet
Green Lima Beans
Tomato Salad
Date Bars

### 13
Prune Juice
Broiled Ham, Toast
•
Split Pea Soup
Calves' Liver
Potatoes au Gratin
Broccoli
Apple and Date Salad
Frosted Gingerbread
•
Spanish Rice
Buttered Asparagus
Orange and Avocado Salad
Bread Pudding

### 14
Half Grapefruit
Bacon Strips
French Toast With Sirup
•
Apricot Juice Cocktail
Roast Leg of Pork
Mashed Potatoes
String Beans
Celery Hearts and Olives
Ice Cream
•
Tomato Bouillon
Hashed Brown Potatoes
Buttered Carrots
Cottage Cheese Salad
Frozen Peaches
Cake

### 15
Baked Apples
Poached Eggs, Toast
•
Corn Chowder
Beef Stew With Vegetables
Parsley Potatoes
Cabbage au Gratin
Pear-Nut Salad
Cottage Pudding
•
Italian Spaghetti
Buttered Peas
Fruit Salad
Chocolate Eclairs

### 16
Tomato Juice
Fried Eggs, Biscuits
•
Vegetable Soup
Spareribs
Boiled Potatoes
Buttered Cauliflower
Pineapple Upside-Down
Cake
•
Assorted Cold Cuts
Southern Corn Pudding
Fresh Fruit Salad
Prune Whip

### 17
Sliced Oranges
Scrambled Eggs, Toast
•
Scotch Broth
Lima Beans
Glazed Sweet Potatoes
New Spinach
Asparagus and Tomato
Salad
Cream Puffs
•
Chicken à la King
Buttered Peas
Carrot and Celery Sticks
Whipped Gelatin on
Pineapple Slices

### 18
Stewed Figs
Poached Eggs on Whole
Wheat Toast
•
Broth With Noodles
Pot Roast of Beef
Buttered Potatoes
Harvard Beets
Head Lettuce Salad
Ice Cream
•
Jellied Veal Loaf
Creamed Diced Potatoes
Grapefruit and Cheese
Salad
Stewed Pears

### 19
Orange Juice
Shirred Eggs, Hot Cross
Buns
•
Clam Chowder
Fillet of Sole
Mashed Potatoes
Stewed Tomatoes
Cabbage Salad
Coconut Cream Pie
•
Tuna Salad With
Tomato Wedges
Potato Chips
Fruit Gelatin With
Whipped Cream
Vanilla Cookies

### 20
Stewed Peaches
Broiled Ham, Preserves
•
Creole Soup
Veal Fricassee
Boiled Potatoes
Buttered Cauliflower
Pear and Apple Salad
Chocolate Pudding
•
Sliced Cold Meat
Cheese
Potato Salad
Buttered Asparagus
Rice Pudding

### 21
Grapefruit Sections
Soft Boiled Eggs,
Marmalade
•
Chicken Broth With Rice
Baked Ham With Raisin
Sauce
Glazed Sweet Potatoes
Buttered New Peas
Spring Salad With
Roquefort Cheese Dressing
Fresh Peach Shortcake
•
Egg Soufflé, Vegetable
Sauce
Stuffed Baked Potatoes
Fresh Fruit Cup
Daffodil Cake

### 22
Pineapple Juice
Bacon Strips, Toast
•
Fruit Cocktail
Roast Lamb With Mint
Jelly
Rissole Potatoes
Julienne Carrots
Sponge Cake With
Lemon Sauce
•
Tomato Bouillon
Macaroni and Cheese
Buttered String Beans
Chef's Salad
Green Gage Plums

### 23
Stewed Rhubarb
Scrambled Eggs, Jelly
•
Creole Soup
Veal Birds
Baked Squash
Head Lettuce
Peanut-Butterscotch
Dessert
•
Baked Idaho Potatoes
Buttered Asparagus
Tomato Stuffed With
Cottage Cheese and Chives
Deep Dish Apple Pie

### 24
Apple Juice
Sausage Links, Toast
•
Cream of Celery Soup
Broiled Liver and Sautéed
Onions
Potatoes au Gratin
Green Beans
Tomato and Lettuce Salad
Date Pudding
•
Salmon Loaf
Buttered Spinach
Perfection Salad
Apricot Halves

### 25
Tomato Juice
Poached Eggs on Toast
•
Mulligatawny Soup
Baked Pork Chops in
Cream
Steamed Potatoes
Mashed Rutabagas
Waldorf Salad
Prune Whip
•
Jelly Omelet
Baked Sweet Potatoes
Vegetable Salad, French
Dressing
Cherry Cobbler

### 26
Stewed Apricots
Bacon Strips, Orange
Biscuits
•
Vegetable Soup
Fillet of Red Snapper
Creamed Potatoes
Buttered Wax Beans
Peach-Cream Cheese Salad
Orange Sherbet
•
Eggs à la King
O'Brien Potatoes
Buttered New Carrots
Mixed Green Salad
Frozen Strawberries

### 27
Applesauce
Soft Cooked Eggs, Toast
•
Oxtail Soup
Roast Beef, Brown Gravy
Browned Potatoes
Buttered Turnips
Blueberry Cobbler
•
Escalloped Ham and
Macaroni
Broiled Tomatoes
Head Lettuce Salad
Lemon Chiffon Pudding

### 28
Grapefruit Juice
Buckwheat Cakes, Honey
•
Cream of Vegetable Soup
Baked Ham
Creamed Potatoes
Baked Squash
Celery, Olives and Pickles
Pineapple Ice Cream
•
Creamed Chicken on Toast
New Peas
Fruit Salad
Burnt Sugar Cake With
Frosting

### 29
Stewed Peaches
Soft Boiled Eggs, Toast
•
Bouillon
Lamb Patties With
Bacon Curls
Corn Pudding
Buttered Cauliflower
Apricot Tart
•
Baked Beef Tenderloin
French Fried Potatoes
Steamed Squash With
Butter
Coleslaw
Fruit Whip

### 30
Baked Apples
Scrambled Eggs, Bacon
•
Julienne Soup
Stuffed Spareribs
Baked Potatoes
Steamed Cabbage
Sliced Orange Salad
Chocolate Chiffon Dessert
•
Sliced Ham
Potato Salad, Hard Boiled
Eggs
Radishes
Maple Nut Ice Cream
Cake

Ready-to-eat or cooked cereals are offered on all breakfast menus.

# *Opinion Is Divided on* Centralized *v.* Decentralized *Refrigeration Systems*

EVERETT W. JONES

THE September 1945 issue of The MODERN HOSPITAL presented an analysis of the returns on the boiler and heating plant section of our recent building and construction questionnaire.

For the hospital that is preparing to meet future refrigeration problems we believe the following study of returns from the refrigeration section of the same questionnaire will be of major interest.

One hundred and forty-two administrators from various sizes and kinds of hospitals and 42 experienced hospital architects sent in complete answers.

The acompanying tabulation summarizes the current thinking of the group.

**Opinions of Hospital Executives and Architects on Refrigeration Equipment**

| *Type of Equipment Desired* | *General Hospitals* | | | *Psychiatric and Tuberculosis Hospitals* | |
|---|---|---|---|---|---|
| | *40 to 99 Beds* | *100 to 249 Beds* | *250 Beds and Over* | *All Sizes* | *Architects* |
| *Number of Answers* | *47* | *44* | *28* | *23* | *42* |
| Central system | 12 | 3 | 2 | 3 | 3 |
| Unit mechanical refrigerators | 10 | 11 | 10 | 4 | 17 |
| Combination of unit and central | 24 | 27 | 16 | 19 | 20 |
| Electric | 38 | 34 | 21 | 21 | 31 |
| Gas | 8 | 3 | 5 | 2 | 6 |
| Kerosene | 0 | 0 | 0 | 0 | 0 |
| Quick-freeze storage | 33 | 37 | 23 | 18 | 28 |
| Ice cream making | 32 | 30 | 23 | 13 | 25 |
| Piped (circulating) ice water | 28 | 23 | 18 | 9 | 23 |
| Central ice-making plant | 22 | 29 | 19 | 11 | 14 |
| Individual ice-making units | 18 | 10 | 7 | 11 | 26 |
| Flake ice machine | 22 | 26 | 20 | 11 | 30 |

### Consider Relative Costs

All too few administrators give careful thought to the relative costs of equipment, installation, power, maintenance and future personnel hours involved in centralized or decentralized (or a combination of the two) refrigeration and ice making. The sanitary and health features of ice making have been too long neglected. A review of the following articles on this subject would be well worth while:

"Sanitation Comes First in Manufacturing Ice," Sidney Bergman, The MODERN HOSPITAL, August 1942.

"Selecting a New System," Sidney Davidson, The MODERN HOSPITAL, May 1941.

"Rules for Refrigeration," John Doherty, The MODERN HOSPITAL, May 1941.

"Decentralized Refrigeration and Ice Making in Hospitals," Albert Snoke, M.D., *Hospitals,* November 1940.

The 1940-45 cumulative index in the current *Hospital Purchasing File* also lists some excellent material on this subject.

An analysis of the table shows about an even preference by small hospitals between central refrigeration (25 per cent) and unit mechanical refrigerators (21 per cent). The administrators of larger hospitals (100 beds and over) voted about 4 to 1 for decentralized systems (unit mechanical refrigerators). Hospital architects were overwhelmingly in favor of unit refrigerators, 41 per cent against 7 per cent. However, a combination of centralized and decentralized systems won the highest vote, the percentage running from 51 to 82.

From observation of the situation in many hospitals all over the country, I believe that a modified centralized plus decentralized system is the answer, that is, the grouping of walk-in and reach-in dietary department boxes, morgue boxes and similar units on one or more self-contained compressor units.

### Brine Lines Replaced

Albany Hospital, Albany, N. Y., was equipped with a centralized refrigeration plant with brine lines running to large and small boxes all over the hospital and the nurses' home. After ten or fifteen years of service most of the brine lines gave constant trouble, requiring an expensive maintenance program. As the longer lines to boxes in the nurses' home and to the many nursing units required extensive maintenance, they were cut off and indi-

vidual unit compressors were installed to handle a few of the boxes. In many cases the old boxes were abandoned and new unit mechanical refrigerators were put in.

After five or six years of this changeover program, the only units left on the central steam-driven compressors were the group of walk-in and reach-in boxes in the dietary department, the central cake ice-making plant and the morgue boxes. This changeover program resulted in a very satisfactory system.

However, had sufficient funds been available, it would have been preferable to have abandoned the central cake ice-making plant in favor of flake ice machines and unit cube ice makers and small hand operated ice cube crushers on the various nursing units.

The question on use of electrical, gas or kerosene powered units resulted in a great preference (75 to 91 per cent) for electrical units. In this connection, we suggest the need for more careful investigation of the gas units. Michael Reese Hospital in Chicago has some interesting data on the operating and maintenance economies that are inherent in the gas units.

The questionnaire disclosed a striking vote for quick, deep-freeze food units. In every classification the vote for this type of equipment was 70 per cent or above.

Well over 60 per cent of the returns called for ice cream making units. Apparently hospital administrators and dietitians are convinced that they can serve better ice cream at a lower cost by making instead of buying it.

Because we failed to include a question on mechanical unit drinking water coolers, the vote for piped circulating ice water is probably misleading.

During the last ten years there has been a significant trend toward unit coolers for drinking water.

### Prefer Central Ice Plants

A surprisingly large number of administrators (approximately 55 per cent) voted for central ice-making plants. Contrasted to this, only 33 per cent of the architects preferred this system. More thought and study given to the sanitary problems involved in making ice in central plants will, it is believed, result in a swing toward the far more sanitary flake ice machines and individual cube ice makers in various parts of the hospital. St. Nicholas Hospital in Sheboygan, Wis., has worked out a fine system of flake ice making and distribution in connection with its central supply room.

When approaching the problem of refrigeration and ice making, careful consideration should be given to these points:

1. Initial capital investment for machinery and equipment.
2. Installation costs.
3. Power costs through the years.
4. Maintenance and repair costs.
5. Freedom from service interruptions.
6. Personnel costs.
7. Last but not least, protection of the health of patients and personnel.

Administrators will profit from a thorough study of their present refrigeration and ice-making system and equipment. It would pay to go over the entire setup with the engineer, find out what problems of operation and maintenance face him and get his ideas.

Conducted by Alta M. La Belle and Jane Barton

# If Housekeepers could have their way

## *Here is what six of them would do—and be*

"WHAT kind of housekeeper would you like to be—and where?"

With the idea of finding out what an executive housekeeper really thinks about herself and her job, the education chairman of the Baltimore chapter of the National Executive Housekeepers' Association tossed that leading question at her fellow members. She asked each one to prepare a brief (unsigned) sketch, detailing her private ideas and ideals in regard to her profession.

Not all of the members complied and, unfortunately, space limitations prevent the publication of all of the answers. However, the following excerpts present a highly interesting composite picture of the model executive housekeeper as these modern executive housekeepers see her.

### I

I would like to be a housekeeper who can live up to the highest standards required by the institution by which I am employed. I realize that the housekeeper is responsible for the cleanliness of the whole hospital and of all residences connected therewith. The housekeeper is also responsible for the supply and maintenance of linens in all departments. Today, more than ever, linens are a big item.

I would like to be the kind of housekeeper who is keen in selecting maids and porters and in placing these workers in just the job that they will best be able to take care of.

I would like to be unprejudiced. I desire to possess a willingness to bear with others whose views differ from my own. I wish to be kind to the personnel under my supervision, but to be quick to distinguish between truth or falsehood.

And now you ask me why? I can only say that to achieve the goal I have set, I must strive daily to carry out in every respect my aims and to keep repeating to myself, "what's worth doing at all is worth doing well."

### II

A memory a mile long that could retain every word and every detail of all I need to know, as well as everyone's face and history.

Such a knowledge of decorating that my touch would always be very sure.

Such patience and understanding that my employes would feel me a tower of strength behind them.

An insight that would let me know how much chance my schemes for improving things have with the management.

These are a few of the things I desire for myself.

As to a situation in which to exercise my god-like qualities—well, first of all, workmen, painters, laundrymen, carpenters, mechanics and upholsterers would be under my own hand. My sewing room force would be able to make draperies and slip covers fit for the Waldorf. My salary would be twice what it is now and all department heads would be twice as cooperative.

A Shangri-La—that's what I want!!

### III

I would like to be the model housekeeper, or should I say my conception of the model housekeeper? So perhaps this paper should be devoted to my description of this perfect housekeeper. Her physical appearance we can dismiss by twisting an old adage slightly that "a house is often judged by the appearance of the housekeeper." The ability to meet the public and to express herself clearly is essential.

But now let us examine the characteristics that make her either a good or a bad housekeeper. To start with let me present this premise: that no department or department head can be any better than the individual workers therein and so it naturally follows that she must obtain the best workers possible either by training them in the work or by hiring well-trained individuals. These should be so thoroughly versed in their duties that they are performed almost automatically and necessitate a minimum of supervision. Pride in performance is a quality which can be built up by the housekeeper who knows her workers.

That she should know color harmonies, the characteristics of various cloth goods, testing methods for materials and various housekeeping products, such as waxes and cleaners, are a few of the necessary qualifications of a good housekeeper.

To say that I would like to work either in Oshkosh or in Skoewhegan would be untrue so let's just go on record as saying I'd be happiest working wherever my colleagues would be efficient, happy and congenial, where our interests would be mutual and our friendships deep.

### IV

My dream is to be a housekeeper in a small hotel of 250 or 300 rooms.

I would like it to be a busy one with a nice clientele and financially able to keep physical property in good condition.

Would like to purchase materials and supervise decorations, especially in several of the more expensive suites.

My dream, too, would include well-paid and well-trained employes so that a smooth-running establishment would be ensured.

Last, but not least, a manager who would understand the problems of the housekeeping department and be interested in them. Would also want to know that he had confidence in my ability and would be back of me and also see that each department cooperated with the others.

(*Continued on Page* 126.)

7. In what way has Airkem proved most valuable to you ?

An Independent research organization asked hundreds of hospital users of AIRKEM this question. Some of the replies are given on this page. "The surgeons remarked at once on the lack of odor" . . . *"No odor. Freshens air. Very little attention to take care of very bad odors"* . . . . "Better than any product tried so far" . . . . *"A pleasant aroma in rooms"* . . . . "Helpful in poorly-ventilated offices" . . . . *"Most effective and easy to use"* . . . . "Makes hospitalization much more pleasant for many patients" . . . . *"The short time it takes to overcome odors"* . . . . "Valuable in controlling odors from cancerous patients" . . . . *"Wick bottle containers save time and energy"* . . . . "Its use does not create an effect on patients sensitive to odors".

# "Keeps odors down and makes hospital smell clean"

## airkem CHLOROPHYLL AIR FRESHENER

Trademark Reg. U. S. Pat. Off.

EASY TO USE


These are just a few of the hospital executives' free expressions of opinion regarding AIRKEM Chlorophyll Air Freshener's effectiveness in controlling odors in hospitals. If you are not already an AIRKEM user, try it on some troublesome odor problem in your hospital.

AIRKEM ends odor problems by adapting one of nature's most effective agents for freshening air in woods and fields — chlorophyll. It is the only air freshener for institutional application which contains chlorophyll — activated for use indoors.

Hospitals all over the country, in increasing numbers, are using AIRKEM to end odor problems and create a fresh-air effect in all departments. The easy-to-use wick bottle, which holds a pint, costs only $1.50 in continental United States. Try it. W. H. WHEELER, INC., 7 East 47th Street, New York 17, N. Y.

## Distributed by leading surgical supply houses

## V

I would like to be the kind of housekeeper who had radar vision that would enable me to locate the maids and trouble at a moment's notice and a walkie-talkie voice that would make it possible for me to give instructions and orders without leaving my office. I would like to have television intelligence that would empower me to know what is going on among the maids and employes in general. I would like to wave a wand and assume a camouflage so that demanding guests would not recognize me in the halls.

Seriously, I would like to be first of all a business woman; then I would make a good housekeeper, for one of the first qualities she must have is to know how to take an order and carry it out. I want to be cooperative with the management in every way; to be able to follow through; to see that the job is finished and well done. Then I would like to be able to encourage all those under me; to have them feel that we are working for the same thing —a smooth, efficient house. I would like to have ability, tact, poise and graciousness.

I would like to have a 500 room modern apartment hotel in a large city in the East with adequate budget to be able to keep the rooms properly set up for beauty and comfort, to be able to put in the things that men enjoy and that women love.

I would like to have this apartment hotel filled with business and professional men and women: the artist, the musician, the writer and the traveler. I would like them to find in me the home-maker and an understanding hostess.

## VI

Naturally, I wish I were able to answer by saying, "The kind I believe I am," but today, with the many problems that have faced us during these past few years, I feel it is impossible to do so intelligently.

An executive housekeeper has many more responsibilities than the average person thinks of, and the success or failure of most any organization may depend to a great extent on her ability. Let's try and analyze this situation. Each room in our hospital represents an individual home and family. Imagine trying to please hundreds of different people throughout the institution, whose ideas of housekeeping vary in nearly every respect since the daily routine of the average home and that of an institution are entirely different. It is difficult to explain to those who are inclined to criticize just why the housekeeping department operates precisely as it does.

Early in the morning, shortly after her employes have reported for duty, the executive housekeeper outlines her plans and her problems for the day and tries to cope with the situation to the best of her ability, making the proper assignments, seeing that all floors are covered, as well as trying to inspect the hospital.

I would like to be able to have all the help I need at all times; adequate supplies and equipment of my own choice, and to impress on everyone with whom I come in contact, especially my fellow workers, the need for greater tolerance.

Cooperation, smiles and kind words are as essential to housekeeping as soap, water and modern equipment and will always help lighten the burdens and make us feel that life is really worth while.

# be regulation ---- but it gets RESULTS!

**"Ever swap your crisp, starched cap for a Sherlock Holmes number and go sleuthing for the villain who "liquidates" towels and sheets?**

**"I did! And know whodunit? Not just *one* villain, but almost half a dozen of 'em! Play Watson, for a minute, and let's see where they hang out—**

***"Villain No. 1 lurks in linen closets*** — it's the voice that says "Forget it!" when you take fresh sheets and towels from the bottom of the stack. *You* know that's right, so those on top work, too.

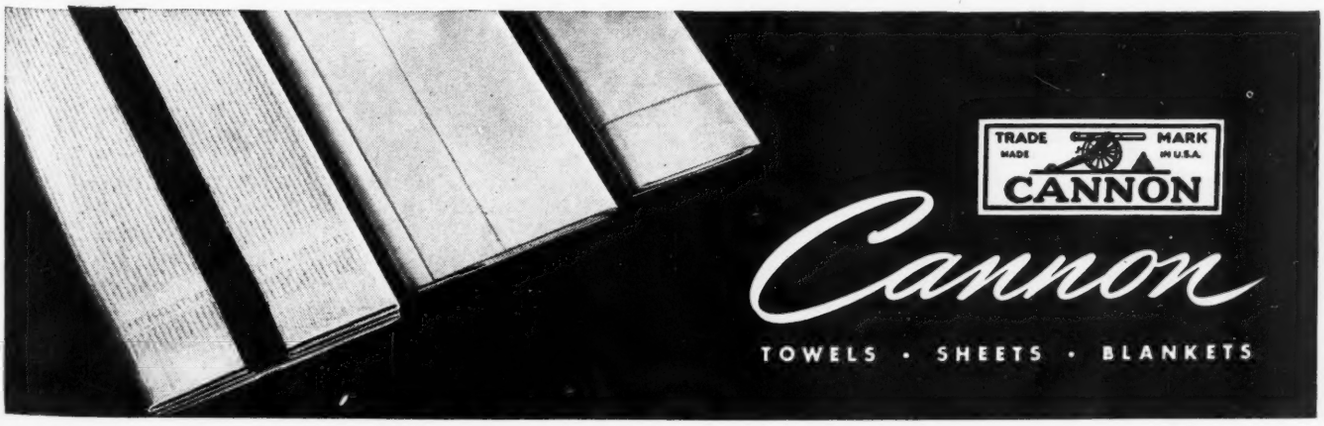
***"Here's Villain No. 2 right now*** — that rough-edged linen hamper! How many times have you noticed how it almost *reaches out* to rip things? Tough customer — better file its claws!

***"A real fiend, that's Villain No. 3*** — the "sharp instrument" mystery stories always talk about. This one's fact, not fiction, though — and it's certain death to sheets and towels unless you keep them safely distant!

***"Villain No. 4 is little, but oh boy!*** Sometimes it's a tear, sometimes a ravel, in a sheet or towel. Don't be fooled because it looks harmless — *sew it*, so it can't grow up to be a great, big nasty hole!

***"Comes now a confession*** — I'm Villain No. 5! Or *was*, until I caught myself using bath towels where a hand towel would do just as well. And even drafting towels for cleaning jobs. But don't shoot—I've sure reformed!

**"While the linen problem's still with us, you'll find it more than pays to foil all these villains, too. Brand-new, grand-new Cannon towels and sheets are coming—fast as they can loom 'em—ah, that will be the day!"**



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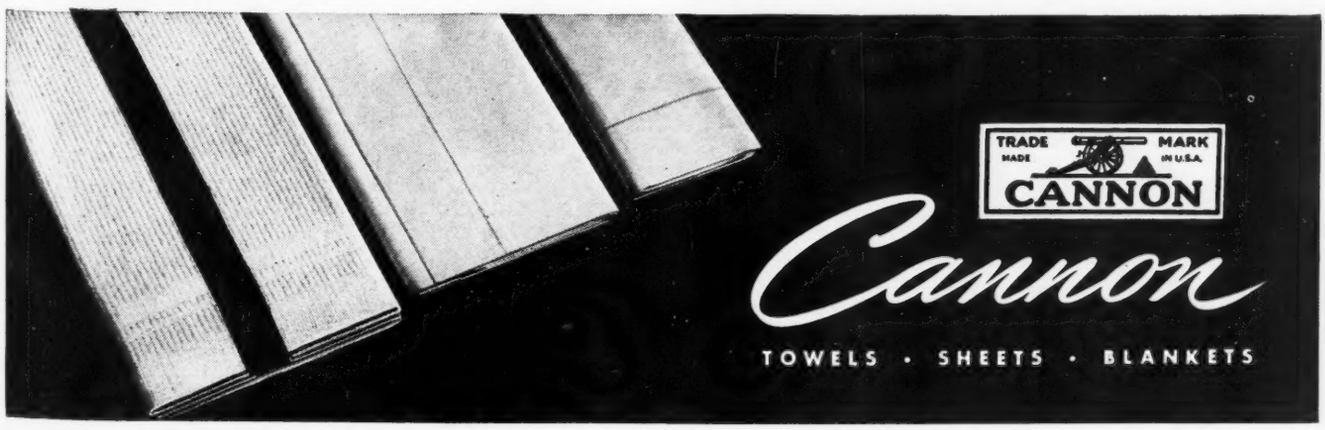


# NEWS IN REVIEW

## Announce Permanent Procedure for Purchase of Surplus Property

By EVA ADAMS CROSS

WASHINGTON, D. C.—Instructions to eligible public health claimants for purchasing surplus property at a 40 per cent discount were announced February 20 by Robert C. Ayers, director, War Property Distribution, F.S.A. The new instructions replace an interim procedure which expired February 16. Hospitals operated by nonfederal governmental agencies, nonprofit hospitals, clinics and public health research organizations are entitled to the discount. Included also among eligible claimant groups are schools of nursing, medicine, dentistry, public health and pharmacy, as well as state, county and local public health agencies.

### Capital and Consumer Goods

Most of the products offered to public health claimants are "consumer goods" and "capital goods." Consumer goods cover such items as clothing, textiles, lunchroom equipment, furniture, office equipment, automobiles, trucks, tires, hardware, surgical and medical equipment, photographic equipment and the like. Capital goods include such items as industrial plant equipment, raw materials other than food, machine tools, electronics equipment, chemicals, metals and transportation equipment.

Field representatives of the U. S. Public Health Service have been assigned to each of the 11 regional consumer goods offices of the War Assets Corporation to screen claimants' orders. Hospitals entitled under S.P.A. Regulation 14 to the discount should send purchase orders directly to the health specialist in the nearest consumer goods office. Each order must be accompanied by a certificate of "need or use" and a letter showing the community benefit to be derived from the applicant's use of the property. The certificate should specifically request the discount and state that the applicant is a health institution as defined in S.P.A. Regulation 14.

"Too much emphasis cannot be placed on the fact that to obtain hospital supplies, particularly of the consumer goods variety, hospitals should have lists already made up and approved by their purchasing authority," a member of the U. S. Public Health Service surplus property staff told THE MODERN HOSPITAL, "so that they can act immediately on receipt of lists showing these goods for sale in the region in which they are located."

In disposing of surplus property to nonprofit health institutions at a discount, criteria for determining distribution on the basis of need has been streamlined to meet the necessity of rapid disposal of such property, Mr. Ayers recently told industry advisory committee meetings of manufacturers and distributors of surgical instruments. Buyers from needier areas are given preference over buyers in the same priority classification from less needy areas.

If a hospital needs normal replacements, it will be rated according to the financial ability of the area to provide itself with health facilities. If it seeks surplus for expansion, lack of existing facilities in the area will also be taken into consideration.

Pending establishment of permanent procedures for the purchase of surplus goods by welfare and charitable institutions, orders from this group will be handled by the U. S. Public Health representative stationed in the W.A.C. sales office. Sales of surplus food will be handled by the U. S. Department of Agriculture.

Inquiries regarding availability of surplus foods should be directed to the U. S. Department of Agriculture, Production and Marketing Administration, Attention: Surplus Property, Washington 25, D. C.

### W.A.C. Regional Offices

The following list shows regional offices of the War Assets Corporation that supply lists of available capital and producers' goods:

*Atlanta,* Ford Building; *Birmingham 3, Ala.,* 2105 Third Avenue, N.; *Boston,* 10 Post Office Square; *Charlotte 2, N. C.,* 317 Tyron Street; *Chicago,* 208 South La Salle Street; *Cleveland,* Newman-Stern Building; *Dallas, Tex.,* 301 Cotton Exchange Building; *Denver,* Boston Building; *Detroit,* Buhl Building; *Helena, Mont.,* Power Block, P. O. Box 177; *Houston 2, Tex.,* 723 Main Street; *Jacksonville 2, Fla.,* Western Union Building, Laura and Duval Streets; *Kansas City 6, Mo.,* 1006 Grand Avenue; *Little Rock, Ark.,* Wallace Building; *Los Angeles 14,* 523 West Sixth; *Louisville,* 421 West Market Street; *Minneapolis 1,* McKnight Building, Sixth Avenue S. and Fifth Street; *New Orleans,* 7020 Franklin Avenue; *Nashville 3, Tenn.,* Consolidated-Vultee Plant; *New York 5,* 70 Pine Street; *Oklahoma City 2,* Cotton Exchange Building; *Omaha 2, Neb.,* Woodmen of the World Building; *Philadelphia 2,* 1528 Walnut Street; *Portland, Ore.,* 310 S. W. Sixth Street; *Richmond 19, Va.,* Richmond Trust Building; *St. Louis,* 505 North Seventh Street; *Salt Lake City,* 101 West Second Street; *San Antonio 5, Tex.,* Transit Tower Building; *San Francisco,* 256 Montgomery Street; *Seattle 4,* Central Building; *Spokane, Wash.,* 610 West Maine Avenue.

## More States Sign Contracts for Local Care for Veterans

WASHINGTON, D. C.—Contracts have been signed or negotiations are underway to offer "home town care" to veterans with service-connected disabilities in states containing an estimated half of the country's population, according to the Veterans Administration. In states in which "home town care" contracts are in operation, a veteran reports to a V.A. office and, once his disability is established as service-connected, he is free to select from a list of cooperating physicians one from his own locality.

Michigan, California, Kansas and New Jersey have entered into such contracts. The Kansas contract was the only one signed directly with the state medical society; the Veterans Administration pays each physician individually. The others are signed with the states' fee-collecting service, which, in turn, reimburses the physicians. Negotiations for contracts providing "home town care" have progressed through the initial conferences with officials in 11 other states. Other state medical groups are considering the arrangement.

"Home town" medical and hospital service has already been initiated by Michigan.

A contract has been made with the Michigan Hospital Association to use beds in practically all of that state's 200 voluntary hospitals for treatment of veterans with service-connected disabilities. Thirty-six additional state hospital associations have approved a proposal to participate with V.A. along the lines of the Michigan contract.

## Navy Nurses Offered Physical Therapy Course

WASHINGTON, D. C.—A nine month course in physical therapy for Navy nurses has started at the Medical College of Virginia in Richmond. This course carries with it full accreditation, so that upon its satisfactory completion, the individual nurse will be a registered physical therapist and entitled to membership in the American Physical Therapy Association.

With its rapidly expanding program of physical medicine, the Navy will have great need for these nurse-physical therapists at all times, V. Adm. Ross T. McIntire stated.

The Navy is also planning several other fully accredited postgraduate courses for its nurses, among them being occupational therapy, psychiatric nursing, teaching and ward management and anesthesia. The course in dietetics now being carried at George Washington University will be continued.

# Veterans Administration Launches $448,000,000 Hospital Building Program

By EVA ADAMS CROSS

WASHINGTON, D. C.—The greatest hospital construction program in the history of the world will be launched by the Veterans Administration in cooperation with U. S. Army Engineers, Gen. Omar N. Bradley announced February 16. Its estimated cost will be $448,000,000. The plans comprise speedy construction of the latest type of fireproof hospitals designed by outstanding hospital architects. In crowded cities, these buildings will be streamlined skyscrapers and, wherever possible, the hospitals will be built close to medical schools and centers.

When the half billion dollar program is completed, the Veterans Administration will have a total of 183 permanent hospitals of all types with a capacity of 151,000 beds. These will include 105 general medical and surgical hospitals, 49 neuropsychiatric hospitals and 29 tuberculosis hospitals. As against the $448,000,000 program, to be completed in the next few years, $270,000,000 has been spent by the Veterans Administration in a program of purchase and construction over a twenty-seven year period. There are now 98 V.A. hospitals in operation with a total bed capacity of 83,339.

To bridge the gap for the nonservice-connected cases during the construction period, arrangements have been made with the armed forces for acquisition of surplus hospitals and supplies to augment facilities so that increased demands for veterans' beds can be speedily satisfied. V.A. has taken over and operates five Army hospitals and will soon obtain 13 others, including one from the Navy. The Navy has agreed to give veterans 9875 beds in its hospitals and provide staffs to care for the patients.

Army and Navy facilities will be used wherever they are available and suitable and when sufficient personnel can be obtained. The most difficult problem in this connection is obtaining staffs of doctors, nurses, attendants and other personnel with which to operate these surplus Army and Navy hospitals. Secretary of War Patterson has agreed to let the Veterans Administration use 10,000 beds but because of forthcoming discharges of doctors and other trained personnel could not make definite commitments in staffing all the beds.

The Army will keep enough surplus medical supplies and equipment to operate 100,000 veterans' hospital beds. The stockpile is reputedly worth $30,000,000 and includes some 50 critical materials, difficult or impossible to obtain in the open market. Although V.A. will have part of the surplus materials made available for five years, it will be allowed only a twelve months' supply of critical items, so that the scarce article can be released for civilian medical uses.

Appropriations have been made for new Veterans Administration hospitals in the folowing cities:

**Branch Office 1** (Conn., N. H., R. I.): At New Haven, 500 bed general medical and 400 bed tuberculosis; at Manchester, 150 bed general medical; at Providence, 400 bed general medical.

**Branch Office 2** (N. Y.): At Albany, 1000 bed general medical; at Brooklyn, 1000 bed general medical; at Buffalo, 1000 bed general medical; at New York City, 1000 bed general medical; at Peekskill, 1492 and 492 bed neuropsychiatric; at Syracuse, 1000 bed neuropsychiatric.

**Branch Office 3** (Del., N. J., Pa.): At Wilmington, 300 bed general medical; at Newark, 1000 bed general medical; at Altoona, 200 bed general medical; at Erie, 200 bed general medical; at Greenville, 1800 bed neuropsychiatric; at Harrisburg, 200 bed general medical; at Lebanon, 527 and 1600 bed neuropsychiatric; at Philadelphia, 1000 bed general medical; at Pittsburgh, 1200 bed general medical; at Wilkes-Barre, 457 bed general medical.

**Branch Office 4** (D. C., Md., N. C., W. Va.): At Washington, 750 bed general medical; at Baltimore, 300 bed tuberculosis; at Fort Washington, 72 bed general medical; at Charlotte, 500 bed general medical; at Durham,

500 bed general medical; at Salisbury, 900 bed neuropsychiatric; at Beckley, 200 bed general medical; at Clarksburg, 200 bed general medical.

**Branch Office 5** (Ala., Fla., Ga., S. C., Tenn.): At Birmingham, 500 bed general medical; at Gainesville, 1000 bed neuropsychiatric; at Tallahassee, 200 bed general medical; S. W. Georgia, 200 bed tuberculosis; at Greenville, 200 bed general medical; at Chattanooga, 500 bed general medical.

**Branch Office 6** (Ky., Mich., Ohio): At Louisville, 750 bed general medical; at Ann Arbor, 500 bed tuberculosis; at Grand Rapids, 200 bed general medical; at Iron Mountain, 250 bed general medical; at Saginaw, 200 bed general medical; at Cincinnati, 750 bed general medical; at Toledo, 1000 bed neuropsychiatric.

**Branch Office 7** (Ill., Ind., Wis.): At Chicago, 600 bed general medical; at Decatur, 250 bed general medical; at Fort Wayne, 200 bed general medical; at Madison, 500 bed tuberculosis; at Tomah, 1172 bed neuropsychiatric.

**Branch Office 8** (Iowa, Minn., Neb., N. D., S. D.): At Iowa City, 500 bed general medical; at Duluth, 200 bed general medical; So. Minn., 200 bed tuberculosis; at Grand Island, 200 bed general medical; at Omaha, 500 bed general medical; at Minot, 150 bed general medical; at Sioux Falls, two 150 bed general medical hospitals.

**Branch Office 9** (Ark., Mo., Okla.): At Little Rock, 500 bed general medical; at Kansas City, 500 bed general medical and 250 bed tuberculosis; at Poplar Bluff, 200 bed general medical; at St. Louis, 500 bed neuropsychiatric; So. Missouri, 1000 bed neuropsychiatric; at Oklahoma City, 1000 bed neuropsychiatric.

**Branch Office 10** (La., Miss., Tex.): At Shreveport, 450 bed general medical; at New Orleans, 500 bed general medical; at McComb, 250 bed general medical; at Tupelo, 200 bed general medical; at Big Spring, 250 bed general medical; at Bonham, 50 bed general and 300 bed domiciliary; at El Paso, 500 bed neuropsychiatric; at Houston, 1000 bed neuropsychiatric.

**Branch Office 11** (Mont., Ore., Wash.): At Miles City, 100 bed general medical; at Klamath Falls, 200 bed general medical; at Portland, 150 bed tuberculosis; at Seattle, 300 bed general medical; at Spokane, 200 bed general medical.

**Branch Office 12** (Ariz., Calif.): At Phoenix, 200 bed general medical; at Fresno, 250 bed general medical.

**Branch Office 13** (Colo., Utah): At Grand Junction, 150 bed general medical; at Salt Lake City, 500 bed neuropsychiatric.

**Total:** 2500 tuberculosis beds; 15,483 neuropsychiatric beds; 22,579 general medical beds; 300 domiciliary beds.

## Public Health Nursing Week

To make the work of the public health nurse better known to the public and to allied professional workers in the field of health, the National Organization for Public Health Nursing, in cooperation with the U. S. Public Health Service, is sponsoring Know Your Public Health Nurse Week April 7-13. Thousands of communities throughout the country are preparing to participate in the observance which is keyed to the slogan, "Open the Door to Health." A publicity kit, leaflets, a special poster and a mat advertisement for newspapers can be obtained from the National Organization for Public Health Nursing, 1790 Broadway, New York 19, N. Y.

## 22 Specialists to Aid Veterans Administration in Psychiatry Problems

By EVA ADAMS CROSS

WASHINGTON, D. C.—A neuropsychiatric advisory committee composed of 22 outstanding specialists has been appointed to assist the Veterans Administration in solving neuropsychiatric problems. Additional specialists may be added to the group later. For the last six months physicians of known ability have been engaged on a part-time basis for consultation work and for teaching in neuropsychiatry and allied fields. More than 175 well-trained and experienced specialists in the field of neuropsychiatry have been obtained for clinic, hospital and administrative positions. Of these, 35 are diplomates of the American Board of Psychiatry and Neurology.

Thirty physicians of the Veterans Administration have been assigned as fellows of the school of psychiatry of the Menninger Foundation in connection with their duties at the Winter General Hospital, Topeka, Kan. More are to follow for such specialized training in neuropsychiatry, neurology and related subjects. This is a pilot neuropsychiatric training unit for V.A. physicians. It will be a pattern for others to be established elsewhere.

A program for "training-on-the-job" has been worked out in addition to the residency project at Winter General under the direction of Dr. Karl Menninger, who has accepted appointment as full-time hospital manager. Under this "training-on-the-job," three or five consultants will give a half day a week each to treating patients and aiding in the training of psychiatrists.

Thirteen of 32 authorized Veterans Administration mental hygiene clinics either are in operation or are soon to be opened. Ten "contract" civilian mental hygiene clinics are in operation and negotiations are in progress with 35 additional clinics for a similar service.

Increased emphasis on medical work by the doctor is being stressed by development of scientific and clinical activities and by measures designed to reduce administrative duties. Plans are in operation for the selection and training of hospital attendants. Clerk-typists are being hired to relieve doctors and nurses of paper work essential to efficient hospital administration. All V.A. hospitals have been given authority to employ locally the number of ward clerk-typists needed.



## Medical Schools Set Up Deans' Committees to Aid Veterans Group

While word comes that Mayo Foundation doctors are planning with Maj. Gen. Paul R. Hawley for participation in the V.A. medical program, the Veterans Administration announced February 16 that more than a third of the nation's Class A medical schools have set up "deans' committees" and are recommending part-time consultants and full-time resident physicians in 20 V.A. hospitals. No Class A medical school has refused to cooperate through a deans' committee in improving the medical facilities in veterans' hospitals.

Seven specialists were recently added to the deans' committee of Mount Alto Veterans Hospital in Washington and 28 physicians were selected by the manager of Mount Alto and this committee, headed by Dr. Walter A. Bloedorn, dean of the George Washington University School of Medicine, and the Rev. David McCauley, S.J., dean of Georgetown University Medical School, to act as senior consultants to the staff of the hospital. All are specialists and are affiliated with the medical schools of Georgetown and George Washington universities.

## Canadian Council Moves

The address of the Canadian Hospital Council has been changed to 280 Bloor Street West, Toronto 5.

## U.S.P.H.S. Report Urges Need for Hospital Construction

By EVA ADAMS CROSS

WASHINGTON, D. C.—Hospital construction along with other matters related to public health holds top billing in current interest in Washington in view of the hearings scheduled before the House on Senate-approved S. 191 March 7 and 8 and with the recently issued annual report of the U. S. Public Health Service plugging construction of hospital and health facilities wherever needed.

Public interest in such matters is reflected, said Surgeon General Thomas Parran in his foreword to the report, in the President's message to Congress asking for a national program for health and medical care. The introduction in the Seventy-Ninth Congress of no fewer than 121 bills relating to public health marks the legislators' recognition of the need of more comprehensive health and medical service.

General hospitals, health centers and other facilities are needed, Doctor Parran declared. In taking advantage of reconversion opportunities, state and local governments should survey their health needs and resources in order that construction and operation of health facilities may be undertaken on the basis of needs and usefulness, he continued. The Surgeon General pointed out that such a program could be effectuated by legislation now pending—S. 191, H.R. 2498 and H.R. 2755.

Doctor Parran emphasized also the training of personnel in sufficient numbers and of adequate qualifications to make up the needed "army of health." The doctor shortage will still obtain, he pointed out, even after the armed services have released many physicians. With a higher national income, the demands for medical services will greatly increase. No plans have been developed to train the added numbers of medical men required. The situations and the needs are the same with respect to other categories of health personnel, he added.



## Demobilization of Medical Hospital Personnel Continues

WASHINGTON, D. C.—The Navy Department recently announced that doctors will get a cut in score from 47 to 45 points on April 15 and to 44 points on May 2. Navy nurses will get a one point cut by May 2 to 25 points. Male hospital corpsmen will be cut to 32 points by May 2, and female hospital corpsmen to 21 points.

According to the Army's most recent announcement, all of the 41,000 doctors, with the exception of approximately 4000, will be back in civilian life by June 30 under present demobilization plans. The new criteria will make it possible for physicians and dentists (except for 800 scarce medical specialists) to be separated on any one of the following: 60 points, 45 years of age, thirty-nine months of active duty. The point score for specialists will be reduced April 1 from 70 to 60.

Army Nurse Corps officers will be released with a score of 25 points, 30 years of age or eighteen months of active duty. The same criteria apply to dietitians and physical therapists, except for length of service which is twenty-four months.

## Antivivisection Law Urged

WASHINGTON, D. C.—Hearings will be held soon on a bill introduced more than a year ago to prohibit experiments upon living dogs in the District of Columbia, according to Congressman Lemke, author of the proposed antivivisection legislation. The bill would make it a misdemeanor for any person to experiment or operate in any manner whatsoever upon any living dog for any purpose other than healing or curing the animal.

## Student Nurses Protest Hospital Rules

Graduate nurses at Delaware General Hospital, Wilmington, went on extra hours to perform the regular duties of nursing students so that service to patients would remain uninterrupted during a brief "sitdown strike" by students on February 27.

Two hundred student nurses refused to leave the hospital dining room for an hour and a half in protest against regulations governing use of cosmetics on duty, social activities and rules covering time off.

According to Clarence A. Hume, superintendent of the hospital, the rules protested by students were only those commonly thought necessary in any well-run, responsible school of nursing.

## COMING MEETINGS

**AMERICAN COLLEGE OF SURGEONS,** Regional Meetings: Hotel Copley-Plaza, Boston, March 18-19; Mount Royal Hotel, Montreal, March 22-23; Hotel Statler, Detroit, March 26-27; Utah Hotel, Salt Lake City, April 8-9; Hotel Multnomah, Portland, April 12-13; Biltmore Hotel, Los Angeles, April 17-18.

**AMERICAN DIETETIC ASSOCIATION,** Netherland Plaza Hotel, Cincinnati, Oct. 14-18.

**AMERICAN HOSPITAL ASSOCIATION,** Hotels Bellevue-Stratford and Benjamin Franklin, Philadelphia, Sept. 30-Oct. 3.

**ARKANSAS HOSPITAL ASSOCIATION,** Hotel Albert Pike, Little Rock, May 17-18.

**ASSOCIATION OF CALIFORNIA HOSPITALS,** San Francisco, April.

**ASSOCIATION OF WESTERN HOSPITALS,** Biltmore Hotel, Los Angeles, May 14-16.

**CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION,** Hotel Poinsett, Greenville, S. C., May 22-23.

**CATHOLIC HOSPITAL ASSOCIATION,** Hotel Schroeder, Milwaukee, June 10-13.

**HOSPITAL ASSOCIATION OF NEW YORK STATE,** Hotel Pennsylvania, New York City, June 10-12.

**HOSPITAL ASSOCIATION OF PENNSYLVANIA,** Hotel Bellevue Stratford, Philadelphia, April 24-26.

**IOWA HOSPITAL ASSOCIATION,** Hotel Fort Des Moines, Des Moines, April 15-17.

**KENTUCKY HOSPITAL ASSOCIATION,** Hotel Brown, Louisville, April.

**LOUISIANA HOSPITAL ASSOCIATION,** Hotel Washington-Youree, Shreveport, March 22.

**MID-WEST HOSPITAL ASSOCIATION,** Hotel President, Kansas City, April 24-26.

**NATIONAL CONFERENCE OF SOCIAL WORKERS,** Buffalo, N. Y., May 19-25.

**NATIONAL COUNCIL OF CATHOLIC NURSES,** Hotel Commodore Perry, Toledo, Ohio, May 24-26.

**NATIONAL EXECUTIVE HOUSEKEEPERS' ASSOCIATION,** Atlantic City, May 21-23.

**NEW JERSEY HOSPITAL ASSOCIATION,** Hotel Dennis, Atlantic City, May 1-3.

**NEW YORK STATE HOSPITAL ASSOCIATION,** New York City, June 10-12.

**NORTH DAKOTA HOSPITAL ASSOCIATION,** Hotel Ryan, Grand Forks, May 9-10.

**OHIO HOSPITAL ASSOCIATION,** Hotel Deshler-Wallick, Columbus, April 2-4.

**PENNSYLVANIA HOSPITAL ASSOCIATION,** Hotel Bellevue-Stratford, Philadelphia, April 24-26.

**TENNESSEE HOSPITAL ASSOCIATION,** Hotel Andrew Johnson, Knoxville, April 8.

**TEXAS HOSPITAL ASSOCIATION,** Hotel Texas, Fort Worth, March 21-23.

**TRI-STATE HOSPITAL ASSEMBLY,** Palmer House, Chicago, May 1-3.

## D. C. Medical Group to Submit Plan of Prepayment for Care

WASHINGTON, D. C.—The District of Columbia Medical Society will probably present in the near future a voluntary sickness insurance plan which is the result of many months of careful study by the society's subcommittee on prepaid medicine and its committee on medical care, it was learned February 18. It is believed that the medical prepayment plan follows the general lines of the pattern set by the American Medical Association. It is assumed also to be a direct answer by organized medicine to President Truman's proposal of a compulsory health insurance system.

The current issue of the medical society's official publication declares in an editorial: "The medical prepayment plan will be submitted to the society sometime early in the year. The society then will have to decide whether it intends to join the majority of medical societies in this country in furthering the establishment of prepaid medicine."

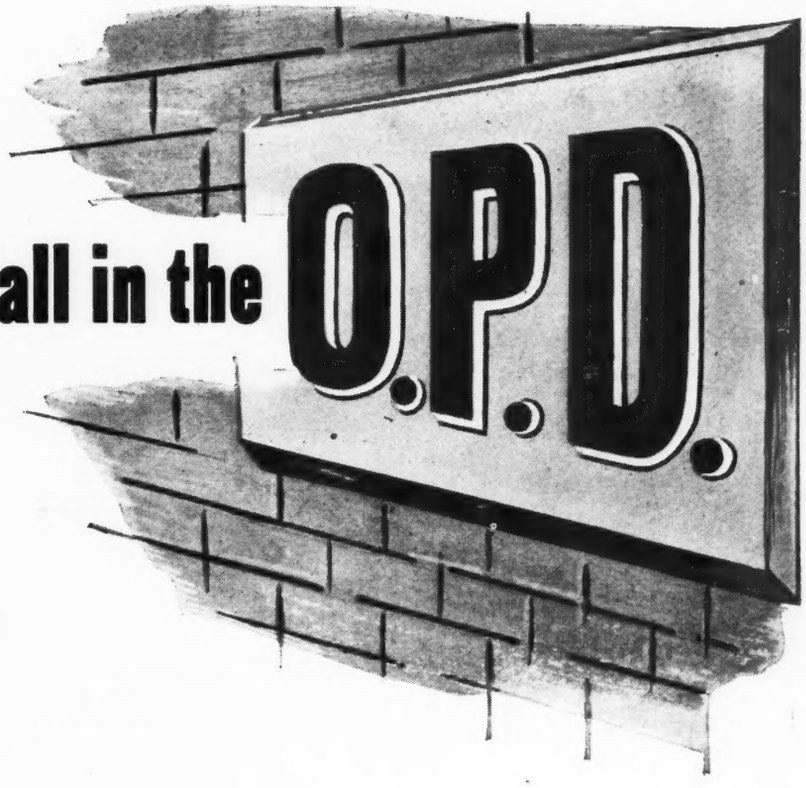
In the meantime, Group Health Association, Incorporated, a medical cooperative of government workers, has launched a program to extend to the general public its prepayment medical and hospital care on a group practice basis. For eight years the service has been confined to federal workers.

## Three Assistants Named

WASHINGTON, D. C.—Three new assistants to the Surgeon General of the Army have been named by President Truman, the Office of the Surgeon General has reported. They are Brig. Gens. Raymond W. Bliss, George S. Beach Jr., and Edward A. Noyes. The new nominations were made to fill the vacancies created by the lapse of terms of Brig. Gens. Larry B. McAfee and Addison D. Davis and Maj. Gen. Shelley U. Marietta. General Bliss was recently appointed deputy surgeon general in addition to his duties as assistant surgeon general.

## Set Up Joint Agency

WASHINGTON, D. C.—The Army and Navy have set up an Army-Navy Medical Procurement Agency in New York City, the Office of the Surgeon General announced February 15. Such an arrangement assures the interchangeability of medical equipment between the two services and unifies purchases of medical supplies. Buying policies under which the agency operates will be determined by a board of four officers, two from each service, and will be under supervision of the Army-Navy Munitions Board.

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## A.M.A. Group Discusses Trends in Licensure, National Health Program

Impact of the war on medicine and medical education, trends toward specialty practice, research in medical schools and recent developments in medical licensure were the subjects discussed at the forty-second annual Congress on Medical Education and Licensure sponsored by the American Medical Association's Council on Medical Education and Hospitals which was held in Chicago February 11 and 12 .

The Veterans Administration program for affiliating veterans' hospitals with medical schools and building new veterans' facilities in which medical research and education can be conveniently carried on was outlined by Dr. Paul B. Magnuson, recently appointed director of research and education for the Veterans Administration.

Problems arising from the increasing trend toward specialization, and particularly the desire of medical officers returning from the armed forces for specialty training, were the subject of one session led by Dr. Ray Lyman Wilbur, chairman of the council. Doctor Wilbur stated that the trend toward specialization is desirable and will inevitably continue.

The speaker declared further that group practice plans of various kinds will become more and more common as time goes on. It was pointed out that the number of doctors seeking hospital residency training now greatly exceeds the number of approved residencies available; the establishment of additional residencies must be safeguarded against lowered educational standards, it was emphasized.

The annual dinner of the federation of state medical boards heard an address by Watson B. Miller, Federal Security Administrator, explaining the government's views on the need for broadening social security to include medical and hospitalization benefits. Mr. Miller quoted national statistics on family income, mortality and morbidity rates and life expectancy to support the claim that federal participation, along the lines embodied in President Truman's national health program, is desirable and necessary. Already, he said, federal, state and local governments are spending a billion dollars a year for health purposes—or about 20 per cent of the total health and medical care bill of the United States.

The need for medical and hospital authorities to keep informed on proposed state, county and municipal legislation seeking to restrict animal experimentation was outlined by Dr. A. J. Carlson, professor emeritus of physiology at the University of Chicago. Doctor Carlson described the efforts of anti-vivisection groups to eliminate research that is essential to scientific advancement.



## Veterans Given Use of Beds in Army Hospital

WASHINGTON, D. C.—A block of 400 beds in the Army's Birmingham General Hospital at Van Nuys, Calif., has been turned over to the Veterans Administration for temporary use for veterans with pulmonary tuberculosis, it was announced here February 10. Facilities made available in the hospital will be staffed by V.A. doctors, nurses and other personnel.

Approximately 15,000 beds will be needed by 1950 for tuberculous veterans, it has been predicted by the assistant director of tuberculosis service of the Veterans Administration. Continuity of treatment has been assured veterans suffering from tuberculosis through arrangements between the V.A. and the Army and Navy for direct admission to V.A. hospitals of all disabled soldiers and sailors requiring further hospitalization at the time of their separation.

## Methodist Association Urged to Analyze Federal Health Projects

Legislation affecting hospitals and other health agencies, training programs for hospital administrators, labor problems in hospitals and trends in nursing education were the principal topics for discussion at the annual convention of the National Association of Methodist Hospitals and Homes in Chicago February 6 and 7.

At the concluding business meeting of the association, Rev. E. L. Gleckler, superintendent of Wesley Hospital, Wichita,, Kan., took over the presidency of the association, and Herman M. Wilsch of Maryland was named president-elect.

At the opening meeting of the hospital group, George Bugbee, executive secretary of the American Hospital Association, reviewed federal activities having to do with hospitals, emphasizing particularly the need for hospital administrators to familiarize themselves with details of the federal legislative program. For example, Bugbee said, many hospital people have expressed themselves in violent opposition to the pending Wagner-Murray-Dingell Bill because of its compulsory health insurance provisions, whereas, actually, many of the bill's other features are worth while and deserve the support of hospital people.

The federal program was also the principal topic discussed by Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, who addressed the first evening meeting of the association. At the same meeting, Mrs. Ellen Woodward of the Social Security Board urged the extension of present social security coverage to include employes of hospitals, religious institutions and other nonprofit organizations. Exclusion of this personnel is presently depriving more than a million persons of social security benefits, Mrs. Woodward said.

Among the other speakers who addressed hospital groups at the meeting were Dr. Frank R. Bradley, superintendent of Barnes Hospital, St. Louis; Dr. C. S. Woods, superintendent of the Methodist Hospital, Peoria, Ill.; Rev. C. C. Marshall, director of the Methodist Hospital, Brooklyn, N. Y.; Mrs. Josie M. Roberts, superintendent, Methodist Hospital, Houston, Tex.; R. A. Nettleton, Iowa Methodist Hospital, Des Moines; John W. Bricker, former governor of Ohio.

Making his annual report to the association, Karl P. Meister of Chicago, executive secretary, indicated that Methodist hospitals and homes are presently valued at $130,000,000. Seventy-one hospitals are now operated by the Methodist Church in the United States, Mr. Meister reported.

## Name Five Physicians to V.A. Medical Department

WASHINGTON, D. C.—The first group of physicians, five veterans of World War II, has received permanent appointments in the new Department of Medicine and Surgery, according to an announcement of the Veterans Administration.

The five physicians are: Dr. Richard Justice Brightwell of Alexandria, Va., who will be chief of the medical rehabilitation divisions in the branch office at St. Louis; Dr. Florence B. Powdermaker of Washington, D. C., who will be chief of psychotherapy and education in the neuropsychiatric service assigned to the central office in Washington, D. C.; Dr. Edward L. Ringer of Lakeland, Fla., who will be the eye, ear, nose and throat specialist assigned to the hospital at Jefferson Barracks, near St. Louis; Dr. Edson H. Steele of Washington, D. C., who will be chief of the neuropsychiatric service at the hospital at Palo Alto, Calif., and Dr. Anthony J. Sweeney of Chicago, who will be assigned to the V.A. center at Columbia, S. C.

## Norby President-Elect of Wisconsin Association

Margaret W. Johnston, superintendent of Beloit Municipal Hospital, Beloit, Wis., took office as president of the Wisconsin Hospital Association at the association's midwinter conference in Milwaukee February 14 and 15. Joseph G. Norby, administrator of Columbia Hospital in Milwaukee, was named president-elect to serve in 1947.

Postwar trends in nursing education were outlined at the banquet meeting by Lucile Petry, director of the U. S. Cadet Nurse Corps program. Miss Petry urged continued sound recruiting efforts for student nurses. Miss Petry also urged that routine nonnursing duties necessarily performed by nurses and nurse students during the war-time personnel shortage be reassigned to nonprofessional aides and housekeeping employes, who could easily be trained to perform such duties in six to twelve month instructional programs.

As a corollary to the need for more nonprofessional nursing care, Miss Petry said, there should be a smaller number of professional nursing schools and a greater number of vocational schools. Through a program of affiliation, students could be sent out to smaller hospitals, she suggested.

George Bugbee, A.H.A. executive director, reported progress on the proposed retirement plan for hospital employes and discussed the whole federal social security and health programs. He advocated consideration by the association of the desirability of legislation looking toward hospital licensure.

Progress on the hospital survey for Wisconsin was reported by Vincent Otis, director of the state survey. The importance of the national hospital survey in the whole hospital program today was outlined by Dr. Roger W. De Busk, executive director of the Evanston Hospital, Evanston, Ill.

Leon R. Wheeler, director of Wisconsin's Blue Cross, urged that hospital administrators, employes and trustees support Blue Cross and help extend the coverage to a larger percentage of the population. The operating agreement and relationship of Blue Cross and the medical prepayment plan sponsored by the Milwaukee County Medical Society was described by James O. Kelley, society secretary.

Fred E. Mott, representing the Wisconsin department of veterans affairs, described the details of admission, reporting and payment procedure voluntary hospitals should use in caring for veterans. Dr. F. W. Madison of Milwaukee, chief of staff at Columbia Hospital, said in an address that public opinion and practice were increasingly concentrating medical care in hospitals; he emphasized the need for good medical staff organization and control.

Prosperity is not the natural heritage of hospitals and will not last, Will Ross of Milwaukee told the meeting. Mr. Ross said he was worried about the effect that today's comparatively prosperous financial conditions will have on hospital trustees, who may think that expenses will have to be cut sharply when stricter financial problems come along—with resulting lowered standards of care. Mr. Ross paid tribute to the war-time priority program for hospitals, which he said on the whole operated fairly and efficiently.

Other officers elected by the association for the coming year were: first vice president, Sister Bernadette, St. Anthony's Hospital, Milwaukee; second vice president, Iva Hartman, Pinehurst Sanatorium, Janesville; treasurer, Dr. M. Rosenswiez, Mount Sinai, Milwaukee.

## Ghormley to Be Consultant

WASHINGTON, D. C.—Dr. Ralph H. Ghormley, Mayo Clinic specialist, will serve as part-time chief of the orthopedic surgery section of the Professional Services Division of the Veterans Administration, Maj. Gen. Paul R. Hawley announced February 22.

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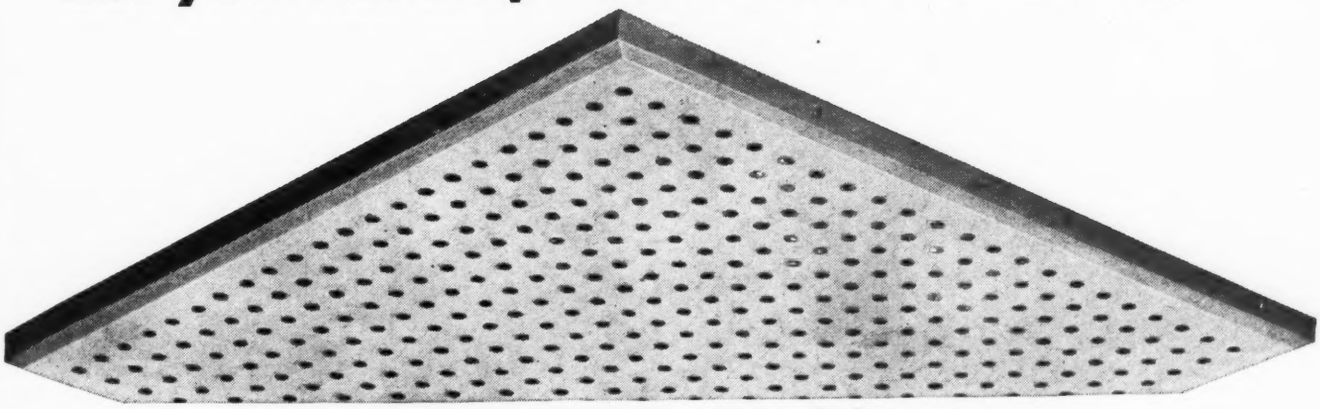

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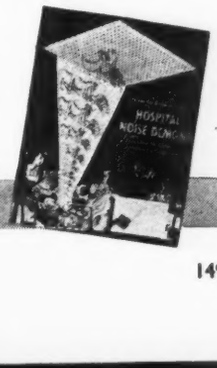


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## Greater New York Group Votes to Establish Public Relations Office

Dr. L. C. Duryea of the Veterans Administration appealed to the voluntary hospitals of the Greater New York Hospital Association at the last meeting in New York City to make available facilities for performing physical examinations of veterans. The veterans' facilities are not able to take care of the more than 13,000 veterans who are awaiting such examinations pending discharge. The meeting carried a resolution to cooperate in every way possible in the care of veterans and also appointed a committee to deal with matters relating to the Veterans Administration.

The association also voted to increase its membership dues by 50 per cent in order to help finance a public relations program. Father Curry of the public relations committee reported that the United Hospital Fund had acted favorably on the request of the association for a grant of $10,000 annually for three years to support the establishment of an executive public relations office. As yet no word had been received as to whether or not the American Hospital Association would grant another $7000 but it was expected momentarily and if the grant is received the association will add the remaining $3000 to make up the budget of $20,000.

It was also announced that there will be more money available for distribution to hospitals this year owing to the success of the United Hospital Fund campaign, the total amount of which now stands at $1,660,404.



## Move Medical Activities of Carlisle Barracks

WASHINGTON, D. C.—The moving of medical activities of Carlisle Barracks, Pa., to Fort Sam Houston, Tex., was completed March 15, Maj. Gen. Norman T. Kirk, Surgeon General of the Army, announced. Certain portions of the basic training program at the Army Service Forces Training Center, Fort Lewis, Wash., have also been transferred to Fort Sam Houston.

Plans have been made for five battalions which will train about 5000 men in basic and technician courses. A basic Medical Department officers' course of approximately 1100 newly commissioned officers will be in continuous operation.

There will be a school of military neuropsychiatry and a school of roentgenology and medical equipment maintenance technician courses. Residency type of training for Medical Corps officers will be carried on at Brooke General Hospital, located at Fort Sam Houston, and also at nine other general hospitals in this country.

## Tribute to Miss Goodrich

An integrated nationwide nursing education program to improve health standards throughout the United States was called for by Annie W. Goodrich, former dean of the Army School of Nursing and of Yale University School of Nursing, at a luncheon sponsored by the *American Journal of Nursing* to celebrate her eightieth birthday in New York, February 26. More than 500 leaders of nursing, hospital administration and medicine attended the meeting, which was marked by a telegram of congratulation to Miss Goodrich from President Truman.

## Announce Contest Date

Closing date for submission of manuscripts to be considered for the Norton Medical Award of $3500 is November 1, the sponsor, W. W. Norton and Company, book publishing firm, has announced. The offer is made to encourage the writing of books on medicine and the medical profession for the layman. Details on requirements and terms can be obtained by writing the sponsor at 70 Fifth Avenue, New York 11, N. Y.

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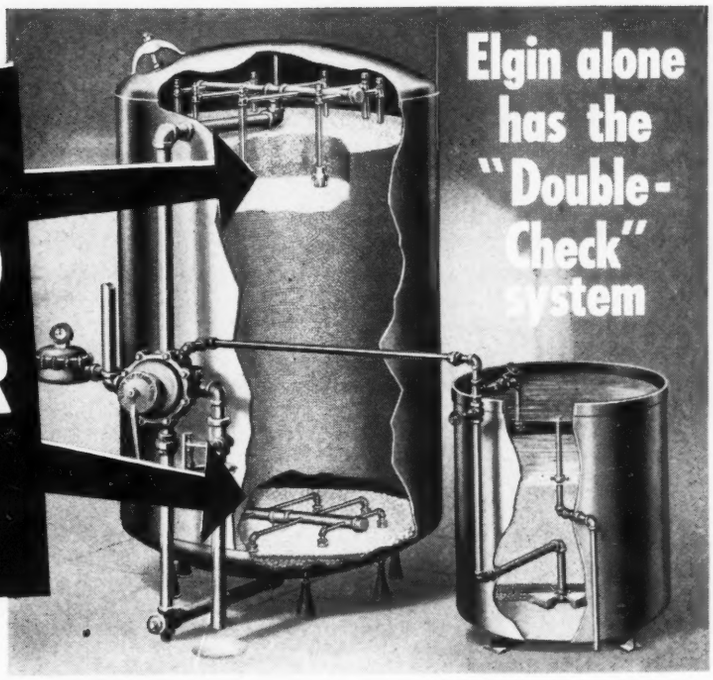


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## Tri-State Theme to Be Planning for Present and Future Needs

The 1946 Tri-State Hospital Assembly will open at the Palmer House, Chicago, May 1 for a three day program, the theme of which is national and local planning for immediate and future hospital needs. One of the features this year will be the three day institute planned by the trustees' section under the direction of Graham L. Davis and his associate, Andrew Pattullo of the Kellogg Foundation.

The first morning's general assembly will be devoted to a discussion of the current surveys of hospital needs under the direction of the Commission on Hospital Care, with speakers on both the national and local levels. That evening, a forum will be conducted on "New Horizons and American Hospitals," coordinated by Dr. Malcolm T. MacEachern, assembly chairman, and Dr. Robin C. Buerki.

Pursuing the same theme of planning, the second day's assembly program will be focused on patients' needs, includings those of veterans, the chronically ill, the tuberculous and ambulatory, and consideration of the patient in planning hospitals. The annual banquet will follow in the evening. The third day's general assembly will consider "Planning for Better Service Through Improving Personnel Relations." A "Dr. I.Q." session will be featured in the afternoon to end the convention on a light-hearted note.

Sectional meetings will be held in the afternoons.



## Service Plans Celebrate "Blue Cross Day"

Blue Cross Day, February 21, was observed by official endorsements of Blue Cross by the governors of 18 states, and similar support from public officials and industrial leaders in most of the major communities served by Blue Cross.

In Rhode Island, the occasion was observed by the presentation of an American Hospital Association award of merit to the Hospital Service Corporation for enrolling more than 50 per cent of the state's population under voluntary Blue Cross protection—the first state to reach this milestone.

C. Rufus Rorem, Blue Cross commission director, spoke at the annual meeting of the Hospital Service Corporation of Rhode Island February 20, recommending a six point program to aid existing voluntary health plans in developing a national health program.

All the 86 Blue Cross plans approved by the Hospital Service Commission were reapproved for 1946 by the board of trustees of the A.H.A. on recommendation of the Blue Cross commission. Approval recognizes that plans measure up to adequate standards of administrative policy, growth during the past year, nonprofit operation and financial position providing adequate protection to the public and to member hospitals. The 86 approved plans include 43 states, the District of Columbia, seven provinces of Canada and Puerto Rico.

## Promote Arthritis Research

A campaign to raise $2,500,000 to establish a foundation for research in arthritis was announced recently in Chicago. The program will seek to add scientific understanding of the causes and treatment of all forms of the disease, which is now estimated to have hundreds of thousands of sufferers in the United States.

The National Arthritis Foundation will establish headquarters at Hot Springs, Ark., according to Louis Kranitz of St. Joseph, Mich., national campaign chairman, in connection with the Levi Memorial Hospital there, which is supported by B'nai B'rith and has treated 185,000 arthritis patients free of charge.

## Announce Examinations for Appointments to U.S.P.H.S. Nurse Corps

WASHINGTON, D. C. — Examinations for the appointment of nurses to the Regular Commissioned Corps of the U. S. Public Health Service have been announced for dates running from March 23 through April 13. The examinations will be held in 15 cities throughout the nation. Candidates will be judged on the basis of professional, general and physical fitness.

Positions are now open in Marine hospitals of the service for nurses in the grades of junior assistant nurse officer, comparable to the rank of Army second lieutenant; assistant nurse officer (first lieutenant), and senior assistant nurse officer (captain).

Salaries in the Commissioned Nurse Corps are the same as for officers of comparable rank in the Army, ranging from $1800 a year base pay with allowance for rental and subsistence to $2400 a year base pay for the three grades mentioned.

## Better Wages, Hours for V.A. Employes

Doctors, dentists and nurses on the staff of the Veterans Administration will enjoy privileges and working conditions not common among employes of any other governmental agency, it was reported following passage of the recent act that created a department of medicine within the Veterans Administration.

The act gives the V.A. medical director, Maj. Gen. Paul A. Hawley, full authority to fix leaves, working hours and other conditions of employment without regard for civil service regulations. Thus, V.A. doctors and nurses will not work on the same schedule as professional employes of other government departments but will instead adjust their work schedules to the requirements of patients and other professional duties. It is expected, too, that salaries in the V.A. medical department will be considerably higher than those common for equivalent service in other departments.

## Campaign for Cardiac Hospital

A movement to establish the first hospital for heart diseases in continental North America has been started by the Variety Club of the Twin Cities, which has launched a campaign to erect a $325,000 heart hospital on the medical campus of the University of Minnesota. With the exception of an institution in Mexico City, no American hospital is specifically devoted to heart disease, according to the *Journal Lancet*.

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## Texas Association Outlines Program

The Texas State Hospital Association has completed plans for its state convention to be held at the Hotel Texas, Fort Worth, March 21-23 when hospital administrators, medical record librarians, occupational therapists and women's auxiliaries will meet concurrently. Nurse anesthetists will begin their meeting on Friday morning, March 22.

The convention will open Thursday afternoon, March 21, with a joint session addressed by Everett W. Jones, vice president of The Modern Hospital Publishing Company, whose subject will be "Personnel and Public Relations." Following this discussion the various associations will begin their separate meetings.

Highlighting Thursday afternoon's session of the Texas Hospital Association will be conclusions from the point of view of the administrator as presented by Tol Terrell, administrator of Harris Memorial Methodist Hospital, Fort Worth, and president-elect of the association.

George Bugbee, executive director of the American Hospital Association, will speak on "National Legislation Affecting Hospitals" at the Thursday evening session.

Dr. Frank Bradley, administrator of Barnes Hospital, St. Louis, and president-elect of the American College of Hospital Administrators, is expected at the convention and will discuss college affiliation. Election of officers is scheduled for Friday morning, March 22.

The annual meeting of the Texas Conference of the Catholic Hospital Association will be held at the Hotel Texas on Wednesday, March 20.



## Blue Cross Directors to Meet in Cincinnati

The semiannual conference of Blue Cross plan directors will be held in Cincinnati March 25 to 27, with an expected attendance of representatives from all the 86 plans now approved by the A.H.A. Commission on Hospital Service. Scheduled are such subjects as national enrollment, with emphasis on inter-plan transfers of membership and reciprocal benefits; government relations, particularly the program for enrolling and paying for hospitalization services to veterans; progress in the formation and integration of medical prepayment plans, and payments to hospitals from Blue Cross plans for services rendered to subscribers.

Recently appointed committee chairmen for the Blue Cross commission are: committee on administrative practice, Leon H. Wheeler, Milwaukee; approval committee, Ray F. McCarthy, St. Louis; enrollment committee, W. H. Lichty, Detroit; government relations committee, J. D. Colman, Baltimore; hospital relations committee, W. S. McNary, Colorado; medical relations committee, M. Haskins Coleman Jr., Richmond, Va.; public relations committee, R. F. Cahalane, Massachusetts; Canadian development committee, E. D. Millican, Montreal.

## Seek Land for State Hospital

An unusual sale of surplus government property was reported in February when the War Assets Corporation authorized the U. S. Department of Agriculture to negotiate with the state of Ohio for a tract of land near Marion, Ohio, to be used for state hospital purposes. The land and existing buildings were part of the Scioto Ordnance Plant, and Ohio welfare department officials are anxious to acquire the 1290 acres and buildings for an urgently needed mental disease hospital. The entire ordnance plant, consisting of 8000 acres, was turned over to the Department of Agriculture for disposal. Terms and conditions of the sale to the state for hospital purposes are subject to the approval of the War Assets Corporation.

## R. I. Blue Cross and Medical Society Announce Surgical Plan

Rhode Island Blue Cross will operate a prepayment surgical care program in cooperation with the Rhode Island Medical Society, it was announced February 20 by Herman C. Pitts, president-elect of the medical society. Surgical benefits will be offered in conjunction with hospitalization, but funds of the two nonprofit organizations will be kept separate, it was explained.

"The coverage will include surgery and obstetrical care either in or out of the hospital," Doctor Pitts stated. "There is no coverage for medical cases as yet, but it is expected that this will be added later as experience is gained and funds are accumulated."

A committee of doctors has been appointed by the R. I. Medical Society to draw up a schedule of fees for doctors under the plan. When these fees have been agreed upon, the Blue Cross will develop rates for subscribers under the new program. The proposed rates and benefits will then be submitted to the state insurance commissioner for approval.

"To give the medical profession a voice in shaping future policies," Doctor Pitts said, "Blue Cross has changed its by-laws so as to include doctors appointed by the medical society to its board of directors in the proportion of one doctor for each four directors. It has also been agreed to leave the writing of a fee schedule entirely and forever in the hands of the medical profession."



## Parran Recommends Greater Activity in Public Health

Enlargement of public health services and facilities, training of additional personnel in the public health fields and increased research in medical and scientific subjects were recommended in the annual report of the U. S. Public Health Service by Surgeon General Thomas Parran.

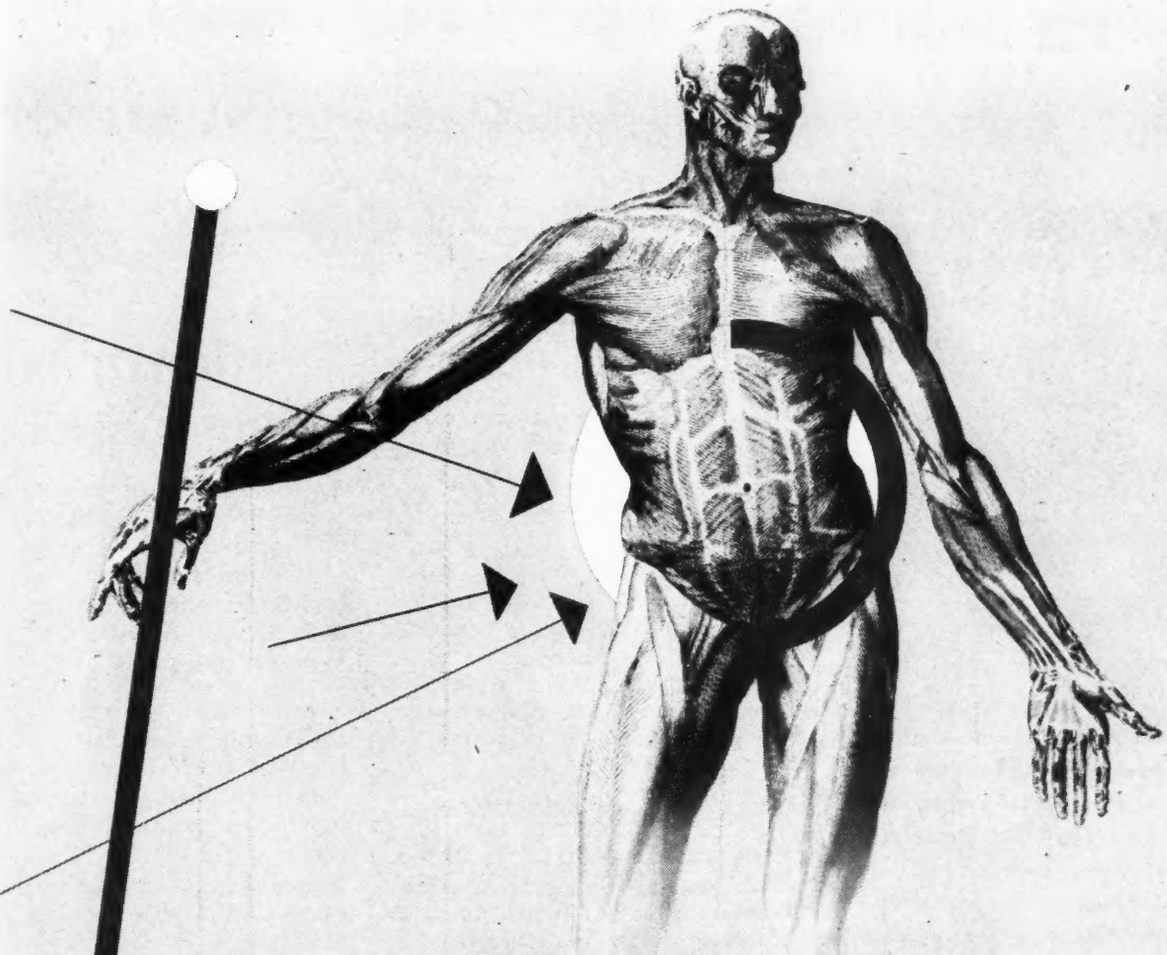
The nation's health did not lose ground during the war, Surgeon General Parran reported, but neither was any improvement apparent during the war years. "Passive maintenance of health standards is not enough. In the years ahead, we must take up aggressively the task of improving the people's health," Doctor Parran declared.

Expansion of preventive medical services, establishment of public health organizations in every community, addition of bedside care to the present services performed by visiting nurses, enlarged sanitation service and inclusion of cancer control and dental care programs were listed as important parts of the plans to build up health activities.

Doctor Parran pointed to the United States Cadet Nurse Corps as illustrative of the governmental training of health personnel. The cadet program met the nursing emergency adequately, Doctor Parran said, and helped the civilian hospital system meet war-time demands in the face of severe staff shortages. War-time medical research, he aded, demonstrated the need for fresh discoveries and wide application of scientific knowledge to improve public health.

## Neff Honored at Inaugural Luncheon

Robert Emery Neff, new superintendent of Methodist Hospital, Indianapolis, was honored recently at an inaugural luncheon attended by church and civic leaders, representatives of medical organizations and of the hospital staff. Featuring the program were a "Prayer of Appreciation" composed by Bishop Titus Lowe, of the Methodist Church, Indiana Area, and chairman of the board of trustees, who presided, and a prayer of consecration by the Rev. Jean S. Milner.



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1. J.A.M.A., 218:9-12, May 5, 1945.

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## Luce Bill Proposes New Department of Science and Research

WASHINGTON, D. C.—The bill to create a Department of Science and Research, introduced by Representative Clare Luce, would have among five bureaus one of public health and social science. The other four bureaus are: physics and mathematical science; scientific education and information; biological sciences, and engineering and technological sciences.

The new agency would be created as an executive department in order to correlate on the highest government level the programs of national defense, national health and proper conservation and use of the production and natural resources of the nation.

The active and continuous voluntary cooperation of all qualified technical and scientific educational institutions would be sought by the head of the department, a Secretary of Science and Research. The help of the professional and learned societies would also be sought in an advisory council to the department. Such a council would have adequate representation of all branches of science.

## Offers Award for Essays on Urology

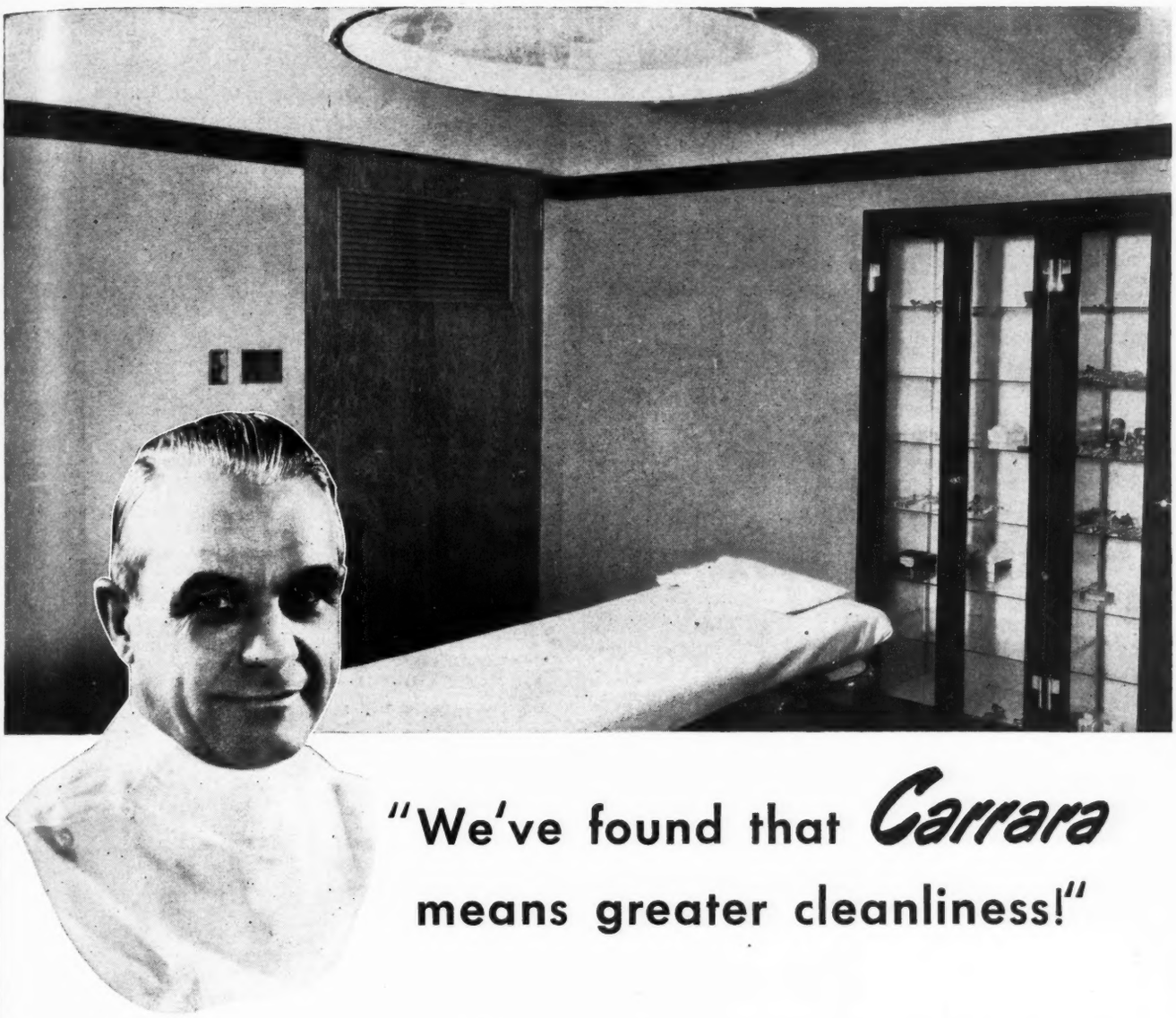
The American Urological Association is offering an annual award "not to exceed $500" for an essay, or essays, on the result of some specific clinical or laboratory research in urology. The amount of the prize will be based on the merits of the work presented and if none is deemed worthy by the committee on scientific research, no award will be made.

The selected essay, or essays, will be presented on the program of the American Urological Association's meeting at the Netherlands Plaza Hotel in Cincinnati, July 22-25.

Competition is limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. Those interested are asked to write Dr. Thomas D. Moore, secretary, 899 Madison Avenue, Memphis 3, Tenn. Essays must be in his hands on or before July 1.

## Hospital Receives Gifts

Moses-Ludington Hospital, Ticonderoga, N. Y., was the recipient of two outstanding gifts during 1945, Lula M. Tuttle, superintendent, reports. They were a respirator from the people of Ticonderoga under sponsorship of the local Elk's Club and a hot pack machine from the residents of Schroon Lake.



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## Philadelphia Hospitals Meet to Organize Advisory Council

Fifty-six persons representing 33 member hospitals of Blue Cross in Philadelphia met recently to discuss the formation of an organization of hospitals to serve in an advisory, consultative and coordinating capacity in solving common hospital problems.

Dr. Philip D. Bonnet, chairman of the committee on hospital service plans of the Philadelphia Hospital Association, as chairman of the meeting, reviewed the origin, possible functions and a suggested form for such an organization.

Nominees for officers and members of the executive board and advisory committee were elected to serve as a provisional organization until a formal election can be held under the constitution which is to be drafted and approved.

## Add to Chicago Hospital

Work on a $400,000 addition to the American Hospital, Chicago, will begin at once, according to Dr. Max Thorek, head of the institution. The new five story addition will be erected on both sides of the present building and will be in part for educational purposes.

## Blue Cross Delivers the Goods

When truck drivers in St. Louis were on strike for several days last month, the St. Louis Hospital Council and Missouri Blue Cross sought and obtained permission from the striking local of the International Brotherhood of Teamsters,


Chauffeurs, Garagemen and Helpers to rent a truck and deliver needed supplies to hospitals. The truck, which carried a large Blue Cross sign, was operated by a former Army sergeant Roland E. Frey, a Blue Cross employe.

## OFFICIAL ORDERS

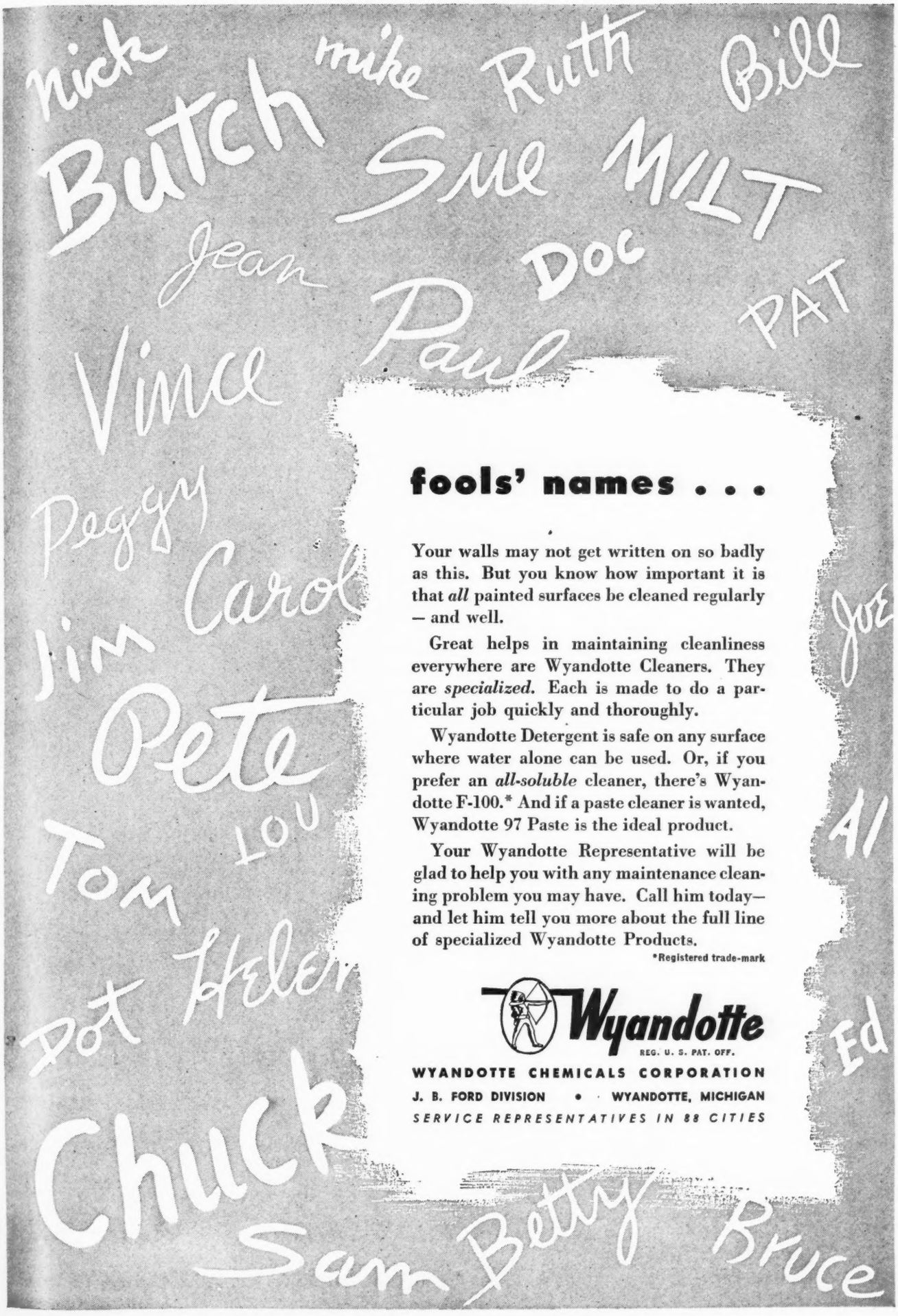
**Drugs and Chemicals.**—The O.P.A. announced liberalization of the standards under which individual adjustments might be granted to manufacturers whose ceiling prices are frozen at March 1942 levels. The action became effective February 19, and applies to all products under the Chemicals and Drugs Price Adjustment Provision.

**Price Controls.**—Effective February 18, wholesale price regulations on furniture have been altered in several respects in order to eliminate inequities. Goods covered by the wholesale furniture regulation and those covered by other regulations may now be listed on the same invoice. Wholesalers handling items that were in their lines during March 1942 no longer need sell such items at their March 1942 prices. They may, if it will result in a higher price, apply their category markup to the cost prescribed by the regulation. All household furniture items for which wholesalers' ceiling prices were previously established by orders under the manufacturers' regulation are now under the coverage of the pricing provisions of the furniture wholesale regulation.

Rubber flooring, with the exception of neoprene, has been increased in cost approximately 11 per cent. This will affect the cost to contractors purchasing such material for use in new buildings. There is no change in retail price.

Manufacturers of rubber mats or matting may apply for individual adjustments in their ceiling prices and any increases granted will be reflected in the retail ceilings in those cases in which the resellers' expense rate is not covered by the present resale price. This order became effective Feb. 18, 1946.

An increase of 14 per cent over manufacturers' Oct. 1, 1941, prices for low-pressure steel boilers became effective on all levels February 16.

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## Merger of Sanatorium, Medical College to Benefit Community

Merger of White Haven Sanatorium, White Haven, Pa., with Jefferson Medical College at Philadelphia has been announced by the board of directors of the 240 bed tuberculosis hospital.

The institution has a decentralized arrangement of its patient and service buildings, having 46 structures on 355 acres of ground. The modern tuberculosis hospital, it is pointed out, is most efficient with a single structure unit for patients. For years, the institution had been noted for research in tuberculosis, but the research had to be discontinued because of the war-time draft of doctors. Although the hospital was physically well equipped for major surgery, the lack of chest surgeons during the war necessitated the sending of patients to New York and Philadelphia.

To correct the foregoing deficiencies and to make available valuable medical opportunities to a larger group of physicians and nurses, the merger was decided. The board of White Haven Sanatorium, which is now in the process of turning over $1,300,000 worth of physical facilities and securities, will remain intact to receive annually the reports on the progress in tuberculosis treatment and research from Jefferson Medical College.

This action is said to be unprecedented inasmuch as the merger is not the usual one of nonprofit hospitals which are processed by the courts. It is said to be unusual, too, for a board of directors to relinquish its responsibilities in the hope that its decision will benefit a larger community.

## Indiana Group Discusses Health, Blue Cross Plans

Future developments as well as current problems were discussed at a meeting of the Indiana Hospital Association March 8 at St. Vincent's Hospital, Indianapolis.

At the luncheon session, Dr. LeRoy Burney, state health commissioner, presented state board of health activities relating to hospitals, and Guy Spring, executive director of the Indiana Blue Cross Plan, spoke on the Blue Cross program and its future. A round table discussion was held later with Dr. Charles Myers of City Hospital, Indianapolis, and Robert Neff of Methodist Hospital, Indianapolis, as leaders. Details of the forthcoming Tri-State Hospital Assembly meeting in Chicago were given by Mrs. Olive Murphy of Bartholomew County Hospital, Columbus.

## Chicago to Buy 10 Ambulances

Specifications have been drawn for the 10 new ambulances which will be purchased by the Chicago Fire Department to form the nucleus of the city's new public emergency ambulance service. The city council has authorized $40,000 for the ambulances, $20,000 for operation and $7000 for radio equipment. The city will place orders with any manufacturing company able to fill requirements or it may attempt purchases through the Surplus Property Administration, Ald. Joseph S. Gillespie explained. Crews trained in Red Cross first aid will be ready when the new ambulances are available.

## Plan Kentucky Medical Center

Plans are underway to raise $1,500,000 to finance the building of a 255 bed hospital at Lexington, Ky., to serve central and eastern Kentucky. Lexington, with two large hospitals, is recognized as the medical center of the area and, with the addition of this projected modern institution to be known as the Central Baptist Hospital, it hopes to become the Rochester of the South. George Hoskins is chairman of the fund-raising campaign, and William A. Kennedy is director of the public subscription phase. Headquarters are at the Phoenix Hotel, Lexington.

## Chicago Nurse Council Broadens Activities

The Central Council for Nursing Education of Chicago will become the Chicago Council on Community Nursing within the next year, it was announced at the council's annual meeting in Chicago February 11. Like its predecessor organization, the Community Nursing Council is expected to promote higher standards of nursing education throughout the metropolitan area, but the scope of the new organization will be broadened to include all public and private nursing agencies, as well as schools of nursing.

The principal address at the annual meeting was given by Samuel A. Goldsmith, chairman of the health division of the Chicago Council of Social Agencies. Mr. Goldsmith described the forthcoming survey of health agencies in the Chicago area that will be made by the U. S. Public Health Service in cooperation with the Chicago Department of Health and Cook County public health agencies.

Mrs. Chester Cook was reelected chairman of the council; Mrs. Charles Wacker was named vice chairman, and Elizabeth Odell, R.N., director of the Evanston Hospital School of Nursing, was reelected secretary.

## Fairmont Hospital Plans Ten Year Expansion Program

Fairmont General Hospital, Fairmont, W. Va., a 150 bed institution built five years ago, plans an extensive expansion program, according to C. Howard Hardesty, president of the board of directors, and Charles E. Vadakin, general manager. Because of vast industrial and community growth, the present plant has outgrown its capacity, and it is planned to enlarge the hospital by 50 bed units to a 300 bed capacity under a proposed ten year program.

The present building will be remodeled, and the clinical laboratory, operating room suite, maternity department, dietary department, pediatric department, storeroom and purchasing department will be expanded. The present power plant and laundry will be moved from the hospital to a separate building.

An addition to the nurses' home will double the bedrooms; a large living room, several parlors and a recreation room will be provided, and classrooms and laboratories will be enlarged. A medical arts building to be used by members of the medical staff is planned.

The total cost of the first unit is estimated at $400,000 and the balance at $800,000. L. D. Schmidt of Fairmont, architect for the original building, has been employed to make the study.

## Issues Preparedness Handbook

With increased traffic on highways and skyways and stepped-up industrial activity forecasting increased disaster hazards, the American National Red Cross has published *Handbook for Nurses, Disaster Preparedness and Relief*, the first nursing manual of its kind. The handbook will provide a reference on nursing functions, an implement in standardizing disaster nursing procedure and a tool in the training of nurses for disaster relief activities. Distribution is scheduled to schools of nursing and colleges and universities offering courses in public health nursing for general information purposes and to all Red Cross chapter nurse vice chairmen for specific preparedness purposes.

## Launch Children's Hospital

With the leasing of the North Chicago Hospital in Chicago, Illinois has inaugurated a new program of hospital care and education of crippled children. An appropriation of $420,000 to cover the cost of the program until June 30, 1947, was authorized at the last session of the legislature.

## Arizona Governor Names Survey Group

Appointments to Arizona's new hospital advisory committee, created by the last state legislature to survey existing hospital facilities in the state and to evaluate their sufficiency, have been announced by Governor Osborn as follows:

Dr. G. C. Salsbury, Ganado, representing the Arizona Hospital Association; Dr. Donald F. Hill, Tucson, representing the Arizona Medical Association; Beatrice Binder, Good Samaritan Hospital, Phoenix, representing the Arizona Nurses' Association; M. M. Larson, Solomonsville, representing agriculture; James C. Jones, Phoenix, representing labor; J. B. Pullen, Clarkdale, representing business.

To be made jointly by the new committee and the state health department, the survey will encompass the location, size and character of all existing public and private hospitals and health centers in the state.

### Enrollment for Veterans

Discharged World War II veterans employed by a company having Blue Cross service may enroll in the Hospital Service Plan of New Jersey during the period February 15 to March 15, regardless of the date of discharge from military service or usual enrollment periods for company employes. The special enrollment opportunity was provided veterans and their families as a step in the plan's public relations program.

## Doctor Accuses Chicago Hospitals of Race Discrimination

Chicago hospitals were accused of racial and religious discrimination in a public address February 17 by Dr. Homer Jack, executive secretary of the Chicago Council Against Racial and Religious Discrimination.

Church sponsored hospitals discriminate against Negroes in admissions, Doctor Jack claimed. "The Christian hospital that discriminates against the Negro or anyone else violates one of the most fundamental tenets of Christianity," Doctor Jack declared. "We must face the fact that most of Chicago's religious hospitals, both Catholic and Protestant, do just that," he added.

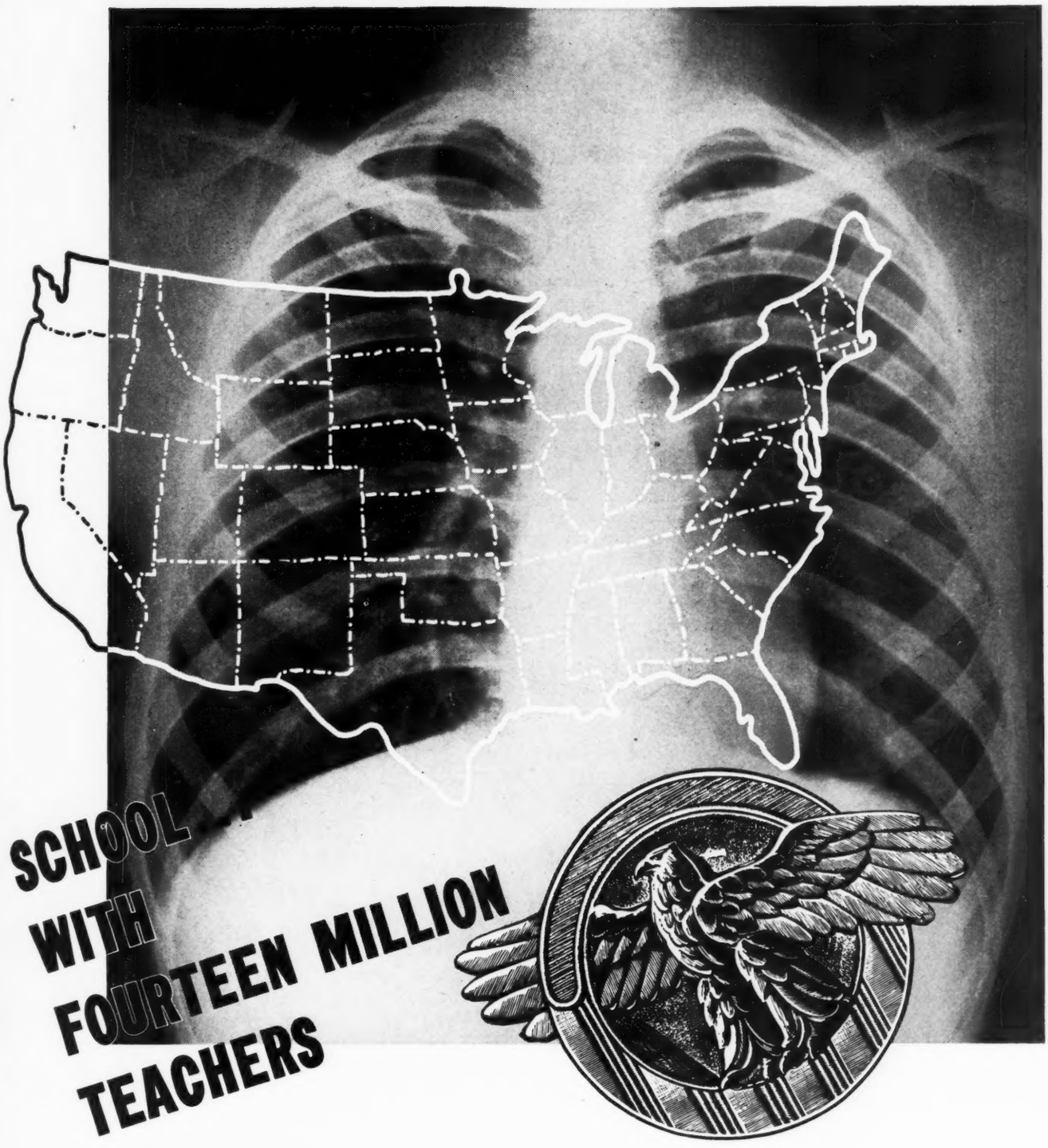
An "antidiscrimination committee" of undergraduates at the University of Chicago leveled a similar charge at the university hospitals a few weeks earlier. The committee claimed that Negro and Oriental patients are not admitted to university clinics on an equal basis with white patients.

## Doctor DeBusk Heads Council

Doctor Roger W. DeBusk, executive director of the Evanston Hospital, was elected president of the Chicago Hospital Council at the annual meeting February 27. Doctor DeBusk succeeds Dr. Herman Smith, director of Michael Reese Hospital. Other officers elected or reelected were: Mrs. Harry Hart, chairman; Rev. John W. Barrett, vice president; Rupert Barry, secretary-treasurer. Trustees named, in addition to Doctor DeBusk and Father Barrett, were Leo Lyons, Dr. A. J. Bachmeyer, C. J. Hassenauer and L. C. Vonder Heidt.

## Woolworth Gives $100,000

George F. Geisinger Memorial Hospital, Danville, Pa., recently received a gift of $100,000 from Charles S. Woolworth of Scranton, Pa., to be used in whatever way the advisory board determines for the best permanent interest of the hospital, W. L. Wilson Jr., administrator, has announced. Mr. Woolworth, who retired as chairman of directors of the Woolworth Store interests a short time ago, has maintained an active interest in Geisinger Hospital's activities for the last two decades. He has served as a member of the hospital's advisory board and given freely of his time and experience.



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> It pays to detect and diagnose incipient disease through periodic examinations—*including chest radiographs.*

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## Report on Baruch Committee

The first annual report of the Baruch Committee on Physical Medicine, prepared by the medical director, Dr. Frank H. Krusen, of the Mayo Clinic, outlines the progress made in attaining the objectives of Mr. Baruch's endowment. Eleven medical schools shared funds in the original grants as follows:

Columbia University, $400,000; New York University, $250,000; Medical College of Virginia, $250,000; Massachusetts Institute of Technology, $50,000; University of Minnesota, $40,000; University of Southern California, $30,000; Harvard University, $25,000; University of Iowa, $15,000; University of Illinois, $15,000; Washington University, $10,000; Marquette University, $5000. Harvard later received a special grant of $30,000 for a special fellowship program.

## Practical Nurse Redefined

The board of directors of the National Association for Practical Nurse Education recently approved the following revised definition of the practical nurse:

"A practical nurse is a person trained to care for subacute, convalescent and chronic patients in their own homes or in institutions, who works under the direction of a licensed physician or registered professional nurse and who is prepared to give household assistance when necessary. A practical nurse may be employed by hospitals, custodial homes, public health agencies, industries, physicians or by the lay public."

## Disability Insurance Passed in California

A disability insurance bill to pay unemployment benefits to persons out of work because of illness or nonindustrial injury has been passed by the California state legislature. Payments of sickness benefits would start in May 1947, but they could be started a year earlier, it is pointed out, if federal consent to use present unemployment insurance funds is granted.

Maximum payments would be $20 a week and could continue for 12.4 weeks in one year, the same period as that set for regular unemployment benefits. An individual could draw both unemployment and sickness payments, although at different times, for a combined total of thirty-five weeks. The 1 per cent employe contribution to the unemployment insurance fund would finance payments.

The assembly refused to adopt an amendment which would relieve physicians of the responsibility of certifying whether an illness was serious enough to keep an employe from work.

## L. A. County to Branch Out

Establishment and operation of branches of the Los Angeles County General Hospital at strategic locations throughout the county have been approved by the Los Angeles County Board of Supervisors. In recommending that the county adopt the branch hospital system, County Manager Wayne R. Allen stated that the outside hospital could be operated at less cost per bed than could the huge general hospital.

From the anticipated state of California postwar funds, the board of supervisors has labeled $1,500,000 to be matched with $1,500,000 in bond funds expected to be approved by voters on June 4 for hospital branches.

## Retire Hospital Mortgages

Under an agreement whereby the certificate holders agreed to accept 40 cents on the dollar as full settlement, a gift of $100,000 from the Surdna Foundation of Yonkers, N. Y., to Yonkers General Hospital brought about retirement of outstanding mortgage certificates of $250,000. J. Dewey Lutes, superintendent, credited John G. Kelly, president of the hospital board, with the achievement, adding that Mr. Kelly had procured an additional gift of $25,000 from an undisclosed source for working capital and improvements.

# Post's "Individuals" are back!

## QUICK! CALL THE DIETITIAN!

Tell her Post's Cereals are back in "Individual," one-serving containers! Tell her she can put the "kinds of cereals they eat at home" back on the patients' diets!

## CALL THE NURSES!

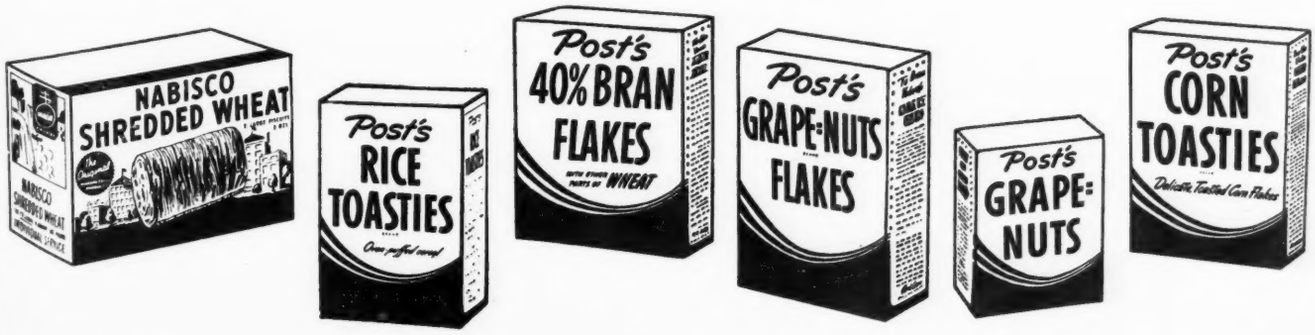
Tell them to disregard any unusual after-breakfast exuberance of the patients . . . the *favorite* cereals are back and substitutes are unnecessary!

## CALL THE KITCHEN!

Tell them Post's Corn Toasties (your old favorite with a new middle name), Rice Toasties (a brand-new Post "Individual"!), original Shredded Wheat, Grape-Nuts, Grape-Nut Flakes, and Bran Flakes can go back on the tray. SIX favorites, instead of four!

## CALL THE PURCHASING OFFICE!

Tell them to get after the General Foods man, right away, about the newly available Post's Cereals in the cheery, brand-new packages!



## ABOUT PEOPLE

(*Continued From Page* 92)

**Stanley R. Schulman** has been appointed administrative intern at Beth Israel Hospital, Boston. Mr. Schulman is a graduate of the Northwestern University course in hospital administration.

### Department Heads

**Mary Buob,** superintendent of nursing at Deaconess Hospital, Spokane, Wash., for the last twenty-three years and assistant superintendent for eight years, has retired from active service. She is a graduate of the school and, with the exception of two years following graduation, has devoted all of her professional service to the hospital. **R. Eline Kraabel,** who has been director of education for the last eight and a half years, has been named Miss Buob's successor and will assume the duties of superintendent of nurses in addition to those of her present post.

**Mrs. Marguerite Cowan** will succeed **Mrs. Helen Blake** as executive housekeeper of Presbyterian Hospital, Chicago, April 1.

**Ralph Rader,** who served three years in the Navy as pharmacist's mate, is the new pharmacist at Bethany Hospital, Kansas City, Kan., succeeding **Mrs. Bessie Leigh,** who resigned.

### Miscellaneous

**Brig. Gen. James Stevens Simmons,** chief of the preventive medicine service of the Office of the Surgeon General of the Army, has been named dean of Harvard University School of Public Health and will assume his new duties July 1.

**Lawrence Campbell,** formerly a hospital administrator in Vermont, is now director of institutions for the state department of public welfare in Vermont.

**Helen L. Bunge,** associate professor of nursing at Frances Payne Bolton School of Nursing of Western Reserve University, Cleveland, will become dean of the school June 30, it has been announced. She will succeed **Marion G. Howell** who is retiring.

**Dr. Sam Parker,** alienist in the New York City Department of Hospitals since 1929, has been appointed director of psychiatry in charge of all psychiatric services in the department. In addition to his new duties, he will continue as director of the psychiatric services at Kings County Hospital.

**Ralph P. Creer,** who was in charge of assembling the Army's collection of illustrations on war wounds, injuries and diseases peculiar to the various theaters of war and who is now on terminal leave as a major, has been appointed a part-time consultant to the Veterans Administration to plan similar work for that agency.

**John H. Begley** has been released from active duty as a captain in the Army after three and a half years' service and will resume his work in Blue Cross with the Chicago Plan for Hospital Care. He will be assistant director in charge of public relations and publicity.

**F. H. Dryden,** director of the Veterans Administration's real estate service, has been named to succeed **Col. George E. Ijams** as assistant administrator for construction and supplies. Colonel Ijams resigned to become national rehabilitation director for the Veterans of Foreign Wars.

**Lt. Comdr. Mary L. Benner,** Nurse Corps, U.S.N., has been awarded the Bronze Star Medal for meritorious service in duties of great responsibility in the 14th Naval District. She is chief nurse at the U. S. Naval Hospital, Aiea Heights, Pearl Harbor, T. H., with additional duties as senior nurse corps officer in the district medical office, 14th Naval District.

**Mrs. Alma H. Scott, R.N.,** has re-

# Variables in Patients—Uniformity in Curity Catgut

PROTEIN IN SURGERY

## Relationship of Protein Deficiency to Wound Healing

"If the total serum protein concentration is found to be less than 5 grams per 100 Ml. of serum, preoperative protein repletion should be attempted, if possible, either by ingestion or intravenous administration of high quality proteins, in order both to reduce the tissue protein deficit and to build up a backlog of protein reserves available for antibody production in the event of developing infection."*

*Cannon, P. R., Wissler, R. W., Woolridge, R. L., and Benditt, E. P.: Relationship of Protein Deficiency to Surgical Infection. Ann. Surg., 120:514, Oct., 1944.

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A COMPLETE bibliography and/or extracts from articles in the literature covering the past 5 years will be furnished on request. Write Dept. D-3, Bauer & Black, 2500 S. Dearborn St., Chicago 16, Ill.

## New Data from Basic Research Result in More Accurate Control of Catgut Absorption

Heat sterilization of chromic catgut is necessary to destroy bacteria, and to prepare sutures, through heat denaturation, for digestion in the body. Uniform, dependable absorption rates can be obtained only by strict control of the sterilizing temperature within narrow limits.

### New Data

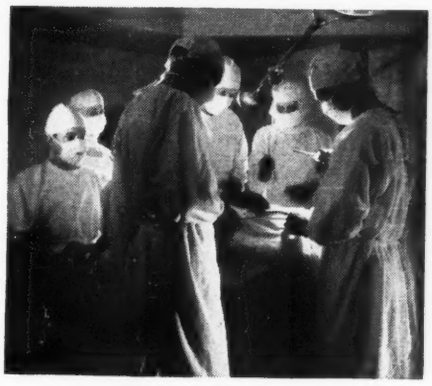
Curity research has discovered two factors, hitherto unrecorded in the literature, which may influence a chromic suture, in extreme cases, to be absorbed even faster than plain catgut:

1 An excess of as little as one or two degrees in temperature over that required for sterility.

2 The length of exposure to the high sterilizing temperature.

### Sterility Plus Absorption Control

Meticulous control of the sterilizing procedure of Curity catgut insures sterility without causing unpredictable absorption performance. Uniformity in Curity sutures helps reduce operation variables to a minimum.



Curity catgut—proved competent in the operating room

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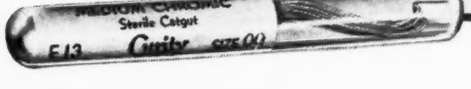

signed as executive secretary of the American Nurses' Association after serving since 1935. Her successor is **Ella Best, R.N.,** associate executive secretary since 1935.

**Leon R. Wheeler** has been named chairman of the administrative practice committee of the American Hospital Association's Blue Cross Commission. Mr. Wheeler is executive secretary of Associated Hospital Service, Inc., Milwaukee.

**James H. Smith** was appointed executive director of the Hospital Service Association of Toledo February 1, the Blue Cross commission office reported. **Fred M. Lees,** who has served as acting executive secretary for the last fourteen months, is now associate director. Mr. Smith was recently discharged from the Army Air Corps, where he held a commission as major. Prior to the war he was in business in Toledo.

### Deaths

**Austin J. Shoneke,** superintendent of Litchfield County Hospital, Winsted, Conn., died March 2. Mr. Shoneke, a former treasurer of the A.H.A., went to Winsted in 1942 after having served for fifteen years as superintendent of New Rochelle Hospital, New Rochelle, N. Y. He formerly had been controller of Mount Sinai Hospital in New York City for eight years.

## Blue Cross Pays for Operation in Japan

Soon after its inception about ten years ago, Milton G. Saltzer of Bronx, N. Y., joined Associated Hospital Service, New York's Blue Cross plan. Five years ago, he had occasion to take advantage of his membership: an appendectomy at the International Catholic Hospital in Tokyo, Japan. In January 1946, he collected—reason for delay: business trip to China, war, arrest and internment.

The amount of the check was $62.79, calculated on the basis of exchange rates current at the time Mr. Saltzer was hospitalized. Lacking about $1 for postage stamps and local telephone calls, it covered practically the entire bill—including a charge of 1.30 yen or 30 cents a day for central heating.

## Spend 5 Per Cent for Research

An estimated 5 per cent of the gross income of the pharmaceutical manufacturing industry was spent for scientific research last year, according to Charles W. Dunn, counsel for the American Pharmaceutical Manufacturers' Association. Dunn told association members at their midyear meeting recently that a survey showed that representative large manufacturers spent an average of 5.5 per cent of income for research, while smaller companies spent 4.1 per cent. On this basis, he said, expenditures for research totaled $12,000,000 to $16,000,000 for the entire industry.

## Navy Encourages Research

WASHINGTON, D. C.—The Office of Research and Inventions, Navy Department, is negotiating unique partnership agreements with scores of universities and industrial laboratories for the purpose of conducting fundamental research in medical science and a number of other fields, an official at the Navy Department said recently.

The Navy provides funds for a university to do research that fits into its normal educational and research program and which is of interest to the Navy. It is estimated that the Navy's program to encourage scientific research will run into millions of dollars.

## Let Contracts for Laundry

Contracts for the building and equipping of a new laundry to cost approximately $85,000 have been let by Abington Memorial Hospital, Abington, Pa., according to James E. Shipley, executive director. Financing of the new structure will be accomplished with funds obtained in the hospital's recent eighth annual appeal.

## Announce New Insecticide

A new insecticide said to be from three to four times as toxic to houseflies and cockroaches as DDT has been compounded under the number 1068 which gives a clue to its composition: 10 atoms of carbon, six of hydrogen and eight of chlorine to the molecule. The empirical formula $C_{10}H_6C_{18}$ gives no clue to the actual structure of the molecule, however, for the same assortment of atoms could be arranged in many different ways. In its evaporation rate, volatility tests have shown that 1068 is intermediate between Gammexane, the British insecticide, and DDT so that the new compound can be expected to last longer than the British poison but not so long as DDT when used in paints or as a residual spray. Little is known as yet in regard to the effect of 1068 on plants and animals other than insects.

## Benjamin Named to Board

Harry W. Benjamin, superintendent of Mount Sinai Hospital, Philadelphia, and president of the Hospital Association of Philadelphia, was elected a new director and 10 other persons were re-elected to the board of the Associated Hospital Service of Philadelphia at the Blue Cross plan's recent annual elections. The new director is one of three Blue Cross board members who represent hospital administrators. Others are Mrs. Helen T. Stabler, superintendent, Montgomery Hospital, Norristown, Pa., and Dr. Lucius R. Wilson, superintendent of Episcopal Hospital, Philadelphia.

## Start Joint Cancer Drive

A coordinated national research program sponsored jointly by the National Research Council and the American Cancer Society and aimed at intensifying the search for the cause and cure of cancer was announced recently. Ninety-one of the foremost cancer authorities in the country were named to direct the intensified research program. Among the scientists were Dr. Harold C. Urey and Dr. Raymond E. Zirkle of the University of Chicago, who were leading members of the scientific group which carried on atomic bomb research there.

## Postpone Nursing Awards

Because many authors who signified their intention of competing have been too heavily loaded with war work to complete their writing, the McGraw-Hill "Book Awards in Nursing Education" have been postponed until September 20. The competition was originally scheduled to close on March 15.

The postponement will not interfere with the company's publishing program; competing authors will have their manuscripts considered for publication upon receipt. Acceptable manuscripts will be published and promoted without delay and considered for an award following the new closing date.

## Plan 135 Bed Addition

St. Peter's Hospital, Albany, N. Y., a general hospital which moved to its present site and erected a 150 bed building in 1931, is starting construction of a 135 bed addition in the spring. Plans for the addition have been prepared by Robert J. Reiley, New York architect, who designed the present building.

## Hospital Given Charter

Allerton Hospital, Brookline, Mass., a general hospital with 50 beds and 20 bassinets, has been awarded a charter as a charitable corporation by the Secretary of State of the Commonwealth of Massachusetts. The group of doctors that founded the Allerton in 1941 as a private institution has donated its total assets, including its original financial investments on which it has received no dividends or interest, to a lay group that will act as trustees for the new charitable hospital.

## Building Booms in First Two Months


Occupancy of nongovernmental hospitals reporting to the Occupancy Chart for January was 80.3 per cent of capacity, up a little from the previous month but about the same as it was all last year. Governmental hospitals reported 71.5 per cent occupancy for January.

Hospital construction projects for the first two periods of 1946 totaled $37,841,302, compared to $21,709,309 for the same period last year and $14,943,614 in 1944. Sixty-one construction projects were reported for the latest period; the 51 projects for which costs were reported came to $18,981,802. Nineteen of these building projects were new hospitals, totaling $7,037,000. Thirty-one additions to existing buildings were reported costing $10,471,195. Among the other projects reporting costs was one new nurses' home reported at $200,000.